



Essays in Ethics and Health Policy

Citation

Player, Candice Teri-Lowe. 2013. Essays in Ethics and Health Policy. Doctoral dissertation, Harvard University.

Permanent link

<http://nrs.harvard.edu/urn-3:HUL.InstRepos:11051184>

Terms of Use

This article was downloaded from Harvard University's DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at <http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA>

Share Your Story

The Harvard community has made this article openly available.
Please share how this access benefits you. [Submit a story](#).

[Accessibility](#)

Essays in Ethics and Health Policy

A dissertation presented

by

Candice Teri-Lowe Player

to

The Interfaculty Initiative in Health Policy

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

in the subject of Health Policy

Harvard University

Cambridge, Massachusetts

May 2013

© 2013 Candice Teri-Lowe Player
All Rights reserved.

Essays in Ethics and Health Policy

Abstract

In 1999 New York enacted Kendra’s Law, in memory of Kendra Webdale, a young woman who was pushed to her death in front of an oncoming train by a man with untreated schizophrenia. Under Kendra’s Law a court can order a person with a mental illness to participate in an “assisted outpatient treatment” (AOT) program. Kendra’s Law includes a number of procedural due process protections including the right to a hearing and the right to counsel. Still critics argue that people with mental illnesses are routinely ordered to participate in the AOT program based on no more than “a bare recital of the statutory criteria.” The first essay in this dissertation, *Outpatient Commitment and Procedural Due Process*, reports the findings from a study on procedural due process and assisted outpatient treatment hearings under Kendra’s Law. Findings from this study suggest that despite the shift from a medical model of civil commitment to a judicial model in the late 1970s, by and large judges continue to accord great deference to clinical testimony. A second paper, *Rethinking Kendra’s Law*, addresses the ethical dilemmas that arise when courts impose AOT over the patient’s objection.

The third paper of this dissertation, *Public Assistance, Drug Testing and the Law*, addresses the Fourth Amendment questions that arise when states condition public assistance benefits on passing a suspicionless drug test. To date eight states—including Florida, Georgia and Missouri—condition public assistance benefits on passing a drug test. Proposals to condition public assistance on passing a drug test have also appeared in Congress. However, without a genuine threat to public health or public safety, proposals to condition public assistance on passing a drug test without individualized suspicion of drug use are unreasonable under the Fourth Amendment. Even if the Supreme Court

were to recognize special needs beyond a genuine threat to public health or public safety, policies that result in withholding public assistance benefits from people who abuse illegal drugs are likely to make many social problems much worse.

CONTENTS

CHAPTER 1. OUTPATIENT COMMITMENT AND PROCEDURAL DUE PROCESS	1
I. PROCEDURAL DUE PROCESS	4
A. CASE LAW	4
1. <i>The Right to a Hearing</i>	6
2. <i>The Right to Counsel</i>	10
3. <i>The Standard of Proof: Clear and Convincing Evidence</i>	11
4. <i>The Right to a Neutral Factfinder</i>	13
B. EMPIRICAL STUDIES	15
1. <i>The Right to a Hearing</i>	15
2. <i>The Right to Counsel</i>	17
3. <i>The Standard of Proof: Clear and Convincing Evidence</i>	19
4. <i>The Right to a Neutral Factfinder</i>	20
C. SUMMARY	23
II. KENDRA’S LAW	24
A. MECHANICS	24
B. DUE PROCESS CHALLENGES.....	27
C. PROGRAM IMPLEMENTATION	31
D. SUMMARY	33
III. METHODS	34
A. DATA COLLECTION.....	34
1. <i>Courtroom Observation</i>	34
2. <i>Participant Interviews</i>	34
B. DATA ANALYSIS	35
IV. RESULTS.....	36
A. AOT HEARINGS	36
1. <i>Uncontested Hearings</i>	36
2. <i>Contested Hearings</i>	37
a. <i>Evidence</i>	40
b. <i>Defense Counsel Activity</i>	42
c. <i>Disposition</i>	42
B. INTERVIEWS.....	43
1. <i>Attorneys</i>	44
a. <i>Impediments to Effective Advocacy</i>	44
i. <i>History of Treatment Noncompliance</i>	44
ii. <i>Expert Testimony</i>	45
iii. <i>Judicial Attitudes Toward the Mentally Ill</i>	46
iv. <i>Medicalization of Deviance</i>	47
b. <i>Attorney Role: Zealous Advocacy or Best Interests?</i>	47
2. <i>Judges</i>	48
a. <i>Deciding AOT Hearings</i>	48
i. <i>Expert Testimony</i>	49
ii. <i>Harm to Others</i>	50

iii. <i>The Revolving Door of Hospital Admissions</i>	50
vi. <i>Liberty Interests</i>	51
b. <i>Clear and Convincing Evidence</i>	52
c. <i>Attorney Role: Zealous Advocacy or Best Interests?</i>	52
V. DISCUSSION.....	53
 CHAPTER 2. RETHINKING KENDRA’S LAW: THE ETHICS OF ASSISTED OUTPATIENT TREATMENT	 59
I. DEINSTITUTIONALIZATION: PITFALLS AND PROMISES	63
II. KENDRA’S LAW	69
III. HARM TO OTHERS	71
A. VIOLENCE AND MENTAL ILLNESS	73
1. <i>Community Surveys</i>	73
2. <i>Psychosis and Violence</i>	75
B. RISK ASSESSMENT AND VIOLENCE	78
C. THE CRIMINAL CIVIL DISTINCTION	81
IV. HARM TO SELF	84
V. IMPAIRED INSIGHT	87
VI. COMPETENCE TO REFUSE TREATMENT.....	92
A. HARM TO SELF.....	95
1. <i>Model Rule: Harm to Self</i>	95
a. <i>Understanding</i>	95
b. <i>Reasoning and Communication</i>	98
B. HARM TO OTHERS.....	105
1. <i>The Insanity Defense</i>	105
2. <i>Model Rule: Harm to Others</i>	108
a. <i>Cognitive Impairment</i>	109
b. <i>Volitional Impairment</i>	110
CONCLUSION.....	115
 CHAPTER 3. PUBLIC ASSISTANCE, DRUG TESTING AND THE LAW: A PUBLIC HEALTH PERSPECTIVE	 115
I. TANF: TEMPORARY ASSISTANCE TO NEEDY FAMILIES	119
A. DRUG TESTING AND THE STATES	120
1. <i>Reasonable Suspicion</i>	120
2. <i>Suspicionless Drug Testing</i>	121

II. THE FOURTH AMENDMENT	123
A. THE SPECIAL NEEDS DOCTRINE	124
1. <i>Public Assistance and the Fourth Amendment</i>	137
a. <i>Lower Court Decisions</i>	137
III. A PUBLIC HEALTH PERSPECTIVE	141
A. THE GOVERNMENT INTEREST.....	143
1. <i>The Probability of the Harm</i>	144
a. <i>National Estimates</i>	144
b. <i>State Estimates</i>	145
c. <i>A Precautionary Principle?</i>	148
2. <i>The Nature and Severity of the Harm</i>	153
a. <i>Taxpayer Subsidy of Illegal Drug Use</i>	154
b. <i>Child Abuse and Neglect</i>	157
c. <i>Drug Use, Unemployment and Public Health</i>	158
B. THE NATURE AND INTRUSIVENESS OF THE SEARCH	160
1. <i>A Fourth Amendment Perspective</i>	162
2. <i>A Public Health Perspective</i>	169
C. EFFECTIVENESS	171
1. <i>Taxpayer Subsidy of Illegal Drug Use</i>	171
2. <i>Drug Use and Employment</i>	174
3. <i>Child Abuse and Neglect</i>	177
a. <i>The Least Intrusive Alternative</i>	179
i. <i>Suspicion-Based Drug Testing</i>	181
D. THE INDIVIDUAL INTEREST IN PRIVACY	183
1. <i>A Fourth Amendment Perspective</i>	183
2. <i>A Public Health Perspective</i>	183
IV. THE UNCONSTITUTIONAL CONDITIONS DOCTRINE	188
A. UNCONSTITUTIONAL CONDITIONS CASES	189
1. <i>Conditions Overturned</i>	189
2. <i>Conditions Upheld</i>	193
B. DRUG TESTING AND UNCONSTITUTIONAL CONDITIONS.....	196
CONCLUSION.....	201
APPENDIX 1	203
APPENDIX 2	210
APPENDIX 3	215
APPENDIX 4.....	220

CHAPTER 1

OUTPATIENT COMMITMENT AND PROCEDURAL DUE PROCESS

In 1999 the New York State Legislature enacted Kendra's Law, in memory of Kendra Webdale, a young woman who was pushed to her death in front of an oncoming train by a man with untreated schizophrenia.¹ Under Kendra's Law, a court can order a person with a mental illness to participate in an "assisted outpatient treatment" (AOT) program. A typical AOT order includes a host of interventions designed to improve medication compliance in the community, among them—periodic blood tests or urinalysis to determine compliance with prescribed medications; counseling and toxicology screens for patients with a history of substance abuse and day or partial day programming.² For those who are not under a supervised housing requirement, courts will sometimes order an "ACT" or assertive community treatment team to visit the patient's home.

A large empirical literature on Kendra's Law has assessed the impact of court ordered treatment on outcomes such as treatment adherence, psychiatric hospitalization and quality of life.³ A smaller number of studies have also examined recipient perceptions of coercion and procedural justice in the AOT program. For example, in a 2009 study of the AOT program, AOT recipients reported mostly positive attitudes about medication and low levels of coercion. When compared to

¹ N.Y. MENTAL HYG. LAW § 9.60 (2006).

² *Id.*

³ See, e.g., Martin S. Swartz, Henry J. Steadman, & John Monahan, NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION, <http://www.omh.ny.gov> (2009) (last visited Sept. 2, 2012); Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, 52 PSYCHIATRIC SERVICES 330 (2001); Jo. C. Phelan, *Effectiveness and Outcomes of Assisted Outpatient Treatment in New York State*, 61 PSYCHIATRIC SERVICES 137 (2010); Alisa B. Busch, *Changes in Guideline Recommended Medication Possession after Implementing Kendra's Law in New York*, 61 PSYCHIATRIC SERVICES 1000 (2010); Bruce G. Link et al., *Arrest Outcomes Associated with Outpatient Commitment in New York State*, 62 PSYCHIATRIC SERVICES 504 (2011).

their counterparts who had not recently participated in the AOT program, current AOT recipients also had more favorable perceptions of procedural justice.⁴

Missing from these studies, however, is a better understanding of procedural due process under Kendra's Law. Kendra's Law includes a number of due process protections including the right to a hearing and the right to counsel. Still critics argue that people with mental illnesses are routinely ordered to participate in the assisted outpatient treatment program based on no more than "a bare recital of the statutory criteria" or the "vaguest allegation of a serious violent act."⁵ Moreover studies on procedural due process and inpatient civil commitment have shown that, for most people with mental illnesses, "the supposed protections of an adversary proceeding" may be "more illusory than real."⁶ Although patients are represented by counsel, attorneys rarely cross-examine clinicians, raise objections, argue for less restrictive alternatives to hospitalization, or investigate the facts alleged to justify civil commitment.⁷ Judges routinely discourage attorneys from taking an active part in commitment proceedings and defer to psychiatrists on questions of mental illness and dangerousness. As one observer said, "[m]any hearings give the impression of being merely a 'rubber stamp' of the psychiatrist's decision, and not a true adversary process."⁸

⁴ See *infra* notes 116-122 and accompanying text.

⁵ Dennis Feld & Kim L. Darrow, *IOC in New York State: At What Price Refusal?*, <http://www.narpa.org> (last visited April 23, 2013).

⁶ *Parham v. J.R.*, 442 U.S. 584, 610 (1979); See also Eric Turkheimer and Charles D. H. Parry, *Why the Gap? Practice and Policy in Civil Commitment Hearings*, 47 AM. PSYCHOL. 646 (1992).

⁷ See *infra* notes 62-71 and accompanying text.

⁸ Mark A. Hart, *Civil Commitment of the Mentally Ill in California: The Lanterman-Petris Short Act*, 7 LOY. L. A. REV. 93 (1974).

This paper reports the findings from a study of procedural due process and assisted outpatient treatment hearings under Kendra’s Law. The study investigated four elements of procedural due process—the right to a hearing; the right to counsel; the standard of proof; and the right to a neutral factfinder. The primary objective of this study was to learn more about how courts determine whether someone meets the criteria for AOT and how much they rely on clinical recommendations. This study also aimed to understand how judges define the term “clear and convincing evidence” and what constitutes clear and convincing evidence that someone meets the criteria for AOT as required by law. Moreover, how do defense attorneys understand their role in AOT hearings? How do they understand their professional obligations to their clients?

Part I traces the evolution of procedural due process and civil commitment. During the first half of the twentieth century, civil commitment decisions were predicated on the “best interests” of the patient and left in the hands of physicians or family members. By the mid-1970s, courts began to prescribe greater procedural due process protections for civil commitment hearings. Since that time the primary site of mental health care in the United States has shifted from large public hospitals to the community, with a particular focus on mandatory outpatient treatment for patients with severe and persistent mental illnesses. However, the fundamental elements of procedural due process have remained the same across inpatient and outpatient settings. Part I discusses *Lessard v. Schmidt* where a Wisconsin district court issued a seminal decision on procedural due process, and *Addington v. Texas*, where the Supreme Court discussed the standard of proof required for civil commitment proceedings. Part I concludes with a review of empirical research on procedural due process and civil commitment. Much of the available case law and empirical research on procedural due process concerns inpatient civil commitment. Nonetheless, Part I will review this literature in detail. The fundamental elements of procedural due process in outpatient commitment settings—e.g. the right to a hearing and the right to counsel—derive from the law of inpatient civil

commitment and these rights have been incorporated into the assisted outpatient treatment program by statute.

Part II turns to the mechanics of Kendra's Law, procedural due process challenges and the assisted outpatient treatment program. Part III outlines the methods used in this study. Much of the research for this paper comes from observing AOT hearings in New York City, as well as candid on-the-record conversations with judges and attorneys, who are involved in Kendra's Law cases. Part IV describes the results. In contrast to early studies on procedural due process and inpatient civil commitment, findings from this study suggest that assisted outpatient treatment hearings in New York City adhere to the basic requirements of procedural due process. At the same time AOT hearings are not without their problems. Attorneys reported significant barriers to effective advocacy on behalf of their clients. Further despite the shift from a medical model of civil commitment to a judicial model in the 1970s, by and large judges continue to accord great deference to clinical testimony. As one judge put it, most judges are not "competent" to overrule clinical recommendations. Nor do judges want to be known in the press as the judge who denied a request for supervised treatment, only to have that person injure or kill a member of the general public. Part V discusses the implications of these findings for the assisted outpatient treatment program.

I. PROCEDURAL DUE PROCESS

A. CASE LAW

Until the late 1960s, the most common form of civil commitment was the two physician certificate, whereby patients were hospitalized on the statement of one or two physicians that they were suffering from a mental disorder and in need of treatment.⁹ In most states, commitment could

⁹ See e.g. N.Y. MENTAL HYG. LAW § 31.27, 31.37, 31.39 (McKinney 1973); See also Robert Miller & Paul Fiddleman, *Changes in North Carolina Civil Commitment Statutes: The Impact of Attorneys*, 11 AM. ACAD. OF PSYCHIATRY & L. 43 (1983);

be achieved without a hearing, without counsel and without legal recourse, save for a writ of habeas corpus.¹⁰ Whenever possible, commitment decisions were left in the hands of family members or physicians.¹¹ By the late 1950s, attitudes toward institutional psychiatry began to change.¹² In the years following World War II, a series of exposés called attention to deplorable conditions in state hospitals.¹³ Labeling theorists and a small group of radical anti-psychiatrists insisted that psychiatric diagnoses were no more than convenient labels designed to suppress nonconforming behavior.¹⁴ So labeled persons deemed mentally ill would in turn reproduce more disturbed behavior. As early as the late 1940s, studies found that psychiatric diagnoses had low rates of interrater reliability¹⁵ and psychiatrists tend to overpredict dangerousness.¹⁶

Paul S. Appelbaum, *The Evolution of Commitment Law in the Nineteenth Century: A Reinterpretation*, 6 LAW & HUMAN BEHAV. 314 (1982); Ellen Dwyer, *Civil Commitment Laws in Nineteenth Century New York*, 6 BEHAV. SCI. & L. 79 (1989).

¹⁰ Miller & Fiddleman, *supra* note 9 at 43.

¹¹ PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 20 (1994).

¹² *Id.* at 4.

¹³ APPELBAUM *supra* note 9, at 27-8.

¹⁴ *Id.* at 4-7.

¹⁵ See, e.g., Ash, *The Reliability of Psychiatric Diagnosis*, 44 J. ABN. & SOC. PSYCH. 272 (1949) (reporting interrater reliability rate of 21%); See also Bruce J. Ennis and Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974); John Monahan, *The Prediction of Violent Criminal Behavior: A Methodological Critique*, in, DETERRENCE AND INCAPACITATION: ESTIMATING THE EFFECTS OF CRIMINAL SANCTIONS ON CRIME RATES 250 (National Academy of Sciences 1978).

¹⁶ One of the more influential studies was conducted by Henry Steadman and Joseph Coccozza following the U.S. Supreme Court decision in *Baxstrom v. Herald*, 383 U.S. 107 (1966). See Henry J. Steadman & Joseph J. Coccozza, CAREERS OF THE CRIMINALLY INSANE: EXCESSIVE SOCIAL CONTROL OF DEVIANCE (1974) (*Baxstrom* resulted in the transfer of 966 psychiatric patients from maximum security hospitals to lower security hospitals or the community. After 4 years Steadman and Coccozza found that only 20% of the Baxstrom patients were reconvicted, mostly for nonviolent offenses, calling the accuracy of dangerousness predictions into question); See also Coccozza & Henry Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence*, 29 RUTGERS L.J. 1084 (1976); JOHN MONAHAN, *THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR* (1981) (concluding that “psychiatrists and

A further critique of psychiatry arose from the civil rights movement. After an initial focus on racial inequality, the postwar civil rights movement gradually expanded to include a concern for the rights of women, the poor and eventually, the civil liberties of people with mental illnesses.¹⁷ Civil rights organizations argued that inpatient commitment standards were vague, overbroad and void for failure to consider less restrictive alternatives to involuntary hospitalization.¹⁸ The actual practice of civil commitment was also under fire. In the late 1960s a small number of states revised their civil commitment statutes to provide for the right to a hearing and the right to counsel. Nonetheless, a widely cited study conducted by students at the University of Arizona Law School documented problems at each stage of the civil commitment process, including the cursory nature of most civil commitment hearings averaging no more than 5 minutes and the tendency by both judges and attorneys to accept conclusory statements from psychiatrists at face value without exploring the facts.¹⁹

1. The Right to a Hearing

In 1972, the Federal District Court for the Eastern District of Wisconsin issued a landmark opinion on procedural due process and civil commitment in *Lessard v. Schmidt*.²⁰ *Lessard* began when

psychologists are accurate in no more than one out of three predictions of violent behavior” among institutionalized patients).

¹⁷ GERALD N. GROB, *THE MAD AMONG US: THE HISTORY OF THE CARE OF AMERICA’S MENTALLY ILL*, 274 (1994).

¹⁸ *Lessard v Schmidt*, 349 F.Supp. 1078, 1093 (E.D. Wis. 1972); *vacated* 414 U.S. 473, *remanded to* 379 F. Supp. 1376 (E.D. Wis. 1984), *vacated* *Schmidt v. Lessard*, 421 U.S. 957 (1975), *reinstated* 413 F. Supp. 1318 (E.D. Wis 1976).

¹⁹ David B. Wexler et al., *The Administration of Psychiatric Justice: Theory and Practice in Arizona*, 13 ARIZ. L. REV. 38 (1971).

²⁰ *Lessard*, 349 F.Supp. at 1081.

Alberta Lessard was picked up by two police officers in front of her home in West Allis, Wisconsin and taken to a mental health center where she was detained on an emergency basis.²¹ Three days later the same police officers appeared before a judge and restated the allegations contained in their petition for emergency detention without Alberta Lessard. Based on that *ex parte* proceeding, a Milwaukee county court issued an order extending the detention of Alberta Lessard for ten days.²² Sometime thereafter a psychiatrist diagnosed her with schizophrenia and the court appointed a guardian *ad litem* to represent her interests. In the weeks that followed, the court extended her commitment order for 30 days, each month, for nearly a year. On her own accord, Lessard obtained counsel and filed a class action in the Federal District Court for the Eastern District of Wisconsin, alleging that the Wisconsin civil commitment statute violated her Fourteenth Amendment right to due process of law.²³

The district court held that the statute was constitutionally defective insofar as it permitted civil commitment without a hearing and failed to afford persons alleged to be mentally ill with timely and effective notice of their right to a hearing. The court held that notice of the hearing must be given in advance of the proceeding so that “[a] reasonable opportunity to prepare will be afforded.”²⁴ Moreover, the right to notice includes more than notice of the date, time and place of the scheduled hearing. “The patient should be informed of the basis for his detention, his right to a jury trial, the standard upon which he may be detained, the names of examining physicians and all

²¹ *Id.*

²² *Id.* at 1081.

²³ *Id.* at 1082.

²⁴ *Id.* at 1092.

other persons who may testify in favor of his continued detention, and the substance of their proposed testimony.”²⁵ Respondents in a civil commitment proceeding were also entitled to notice of the privilege against self-incrimination. Nor does the state accord due process to persons facing civil commitment through an “*ex parte* proceeding in which the individual has no meaningful opportunity to be heard either because of incapacity caused by medication or lack of counsel.”²⁶

As historian Paul Appelbaum writes, “*Lessard* reflects the ethos of its era.”²⁷ In a series of decisions beginning with *Kent v. the United States*²⁸ in 1966 and *In re Gault*²⁹ in 1967 the United States Supreme Court addressed the use of civil commitment in juvenile delinquency proceedings. In both cases the Supreme Court considered and flatly rejected the state’s contention that the therapeutic goals of the juvenile justice system were sufficient to justify civil commitment without the procedural safeguards found in criminal proceedings. Nor was the Supreme Court persuaded that officers in the juvenile justice system could make accurate decisions through informal proceedings. “Failure to observe the fundamental requirements of due process has resulted in instances which might have been avoided, of unfairness to individuals and inadequate or inaccurate findings of fact.”³⁰ The Court continued:

²⁵ *Id.*

²⁶ *Id.*

²⁷ APPELBAUM, *supra*, note 9, at 28.

²⁸ 383 U.S. 541 (1966).

²⁹ 387 U.S. 1 (1967).

³⁰ *Id.* at 19.

The history of American freedom is in no small measure, the history of procedure...[T]he procedural rules which have been fashioned from the generality of due process are our best instruments for the distillation and evaluation of essential facts...It is these instruments of due process which enhance the possibility that truth will emerge from the confrontation of opposing versions and conflicting data.³¹

Without the safeguards of a vigorous adversary system, civil commitment decisions risked arbitrariness and unfairness. Nor was the Court persuaded that less stringent safeguards are required insofar as commitment proceedings are classified as “civil” rather than “criminal.”³² Given the potential loss of liberty, the Supreme Court held that delinquency proceedings must comply with the requirements of due process.

In the same way *Lessard* underscored the stigma of involuntary hospitalization, the loss of basic civil liberties accompanying civil commitment and the virtues of an adversary system. Psychiatric patients lost the presumption of competence, the right to sue and be sued, the right to contract, the right to sit on a jury, the right to vote and the right to drive.³³ “It is obvious,” the court wrote “that the commitment adjudication carries with it an enormous and devastating effect on an individual’s civil rights. In some respects, such as the limitation on holding a driver’s license, the civil deprivations which follow civil commitment are more serious than the deprivations which accompany a criminal conviction.”³⁴ Given the loss of basic liberties, the court concluded that the individual interest in avoiding civil commitment was at least as serious as the interest in avoiding criminal conviction. Therefore, civil commitment required the same rigorous procedural safeguards found in criminal proceedings.

³¹ *Id.* at 21.

³² *Id.* at 23.

³³ *Lessard v Schmidt*, 349 F.Supp. 1078, 1089 (E.D. Wis. 1972).

³⁴ *Id.*

2. The Right to Counsel

Lessard held that persons facing civil commitment have a due process right to counsel, specifically adversary counsel, including appointed counsel if they are unable to afford one. The district court reasoned that “the right to be heard would be, in many cases, of little avail if it did not comprehend the right to be heard by counsel.”³⁵ The court also outlined the essential functions of counsel: “The individual whose freedom is in jeopardy needs the assistance of counsel to cope with problems of law, to make skilled inquiry into the facts, to insist upon regularity of the proceedings, and to ascertain whether he has a defense and to prepare and submit it.”³⁶ The court rejected the state’s assertion that the appointment of a guardian *ad litem* should satisfy the requirement of defense counsel.³⁷ The role of the guardian *ad litem* is to evaluate the “best interests” of his client for himself and present his evaluation to the court. *Lessard*, by contrast, envisions an adversarial role for counsel.

Notwithstanding the strong preference for adversary counsel expressed by the court in *Lessard*, whether attorneys should adopt an adversarial posture in civil commitment hearings remains a matter of some controversy. Although attorneys are bound by the rules of professional ethics, *The Model Rules of Professional Conduct* provide little guidance.³⁸ Rule 1.14(a) Client With Diminished Capacity, states that when a client’s capacity to make adequate decisions is diminished due to mental impairment, “the lawyer shall, as far as possible, maintain a normal client-lawyer relationship with the client,” meaning “a lawyer shall abide by the client’s decision concerning the objectives of

³⁵ *Id.* at 1097.

³⁶ *Id.* at 1098.

³⁷ *Id.* at 1099.

³⁸ AMERICAN BAR ASSOCIATION, MODEL RULES OF PROFESSIONAL CONDUCT (1983).

representation.”³⁹ Yet, as critics point out, Rule 1.14(b) largely vitiates the strength of Rule 1.14(a).⁴⁰ Rule 1.14 (b) provides: “[w]hen the lawyer reasonably believes that the client has diminished capacity [and] is at risk of substantial physical, financial or other harm unless action is taken and cannot adequately act in the client’s own interest, the lawyer may take reasonably protective action,” for example consulting with others who can protect the client or appointing a guardian ad litem.⁴¹ Thus while Rule 1.14(a) directs attorneys to maintain a normal client-lawyer relationship, Rule 1.14(b) suggests a best interests model and leaves attorneys to determine which approach is appropriate.

3. The Standard of Proof: Clear and Convincing Evidence

Prior to *Lessard v. Schmidt*, Wisconsin law permitted a judge or jury to order civil commitment if the court was satisfied that the person was mentally ill or infirm and “a proper subject for custody and treatment” based on a preponderance of the evidence.⁴² *Lessard* held that the statute was unconstitutional insofar as it permitted civil commitment without proof of mental illness and dangerousness to self or others beyond a reasonable doubt. In doing so, the district court drew on *Humphrey v. Cady*, where the Supreme Court intimated that civil commitment requires proof of harm to self or others and characterized civil commitment as “a massive curtailment of liberty.”⁴³

³⁹ *Id.* at 227

⁴⁰ See e.g. Susan Stefan, *The Right to Counsel in Civil Commitment Proceedings*, 9 MPDLR 9, 230 (1985) .

⁴¹ AMERICAN BAR ASSOCIATION, *supra* note 38 at 227.

⁴² *Lessard v Schmidt*, 349 F.Supp. 1078, 1093(E.D. Wis. 1972).

⁴³ *Id.* at 1093, citing 405 U.S. 472, 1052 (1972).

Several years later, the Supreme Court addressed the standard of proof required in civil commitment proceedings directly in *Addington v. Texas*.⁴⁴ *Addington* began when a jury found that Frank Addington was mentally ill and required hospitalization based “clear, unequivocal and convincing” evidence.⁴⁵ Addington appealed on the ground that civil commitment by less than proof beyond a reasonable doubt violated his right to procedural due process. In an opinion by Chief Justice Burger, the Supreme Court held that while the individual interest in the outcome of a civil commitment proceeding is of sufficient gravity to require more than a preponderance of the evidence, in a civil commitment proceeding, the Fourteenth Amendment requires no more than “clear and convincing evidence.” Contrary to *Lessard*, proof beyond a reasonable doubt is not constitutionally required.

The Chief Justice noted significant differences between a civil commitment proceeding and a criminal prosecution. Setting aside arguments to the contrary in *Gault*, the Chief Justice reasoned that in a civil proceeding states do not exercise their power punitively; therefore, the criminal law standard of proof is not required. Second, even if an erroneous civil commitment is as undesirable as an erroneous conviction, “layers of professional review” as well as “the concern of family and friends generally will provide continuous opportunities for an erroneous commitment to be corrected.”⁴⁶ Third, the central inquiry in a civil commitment proceeding is very different from the central issue in a criminal prosecution. In the latter, the central issue is a question of fact, susceptible to objective proof—“did the accused commit the act alleged?”⁴⁷ In a civil commitment

⁴⁴ 441 U.S. 418, 432 (1979).

⁴⁵ *Id.* at 428.

⁴⁶ *Id.* at 428.

⁴⁷ *Id.* at 429.

proceeding, the central inquiry involves the meaning of the alleged facts, which must be interpreted by psychiatrists. Given the uncertainty of prediction and the fallibility of diagnosis, proof beyond a reasonable doubt would impose a standard that states cannot meet.⁴⁸

As the Chief Justice explained, the purpose of a standard of proof is to allocate the risk of error between litigants and impress the importance of the decision upon the factfinder. The standard of proof also “reflects the value society places on individual liberty.”⁴⁹ At the same time, the Court conceded that at least, “to a degree,” the difference between a preponderance of the evidence, clear and convincing evidence, and proof beyond a reasonable doubt may well be “largely an academic exercise.” Moreover:

We can probably assume...that the difference between a preponderance of the evidence and proof beyond a reasonable doubt...is better understood than either of them in relation to the intermediate standard of clear and convincing evidence.⁵⁰

Addington left the term “clear and convincing evidence” undefined; however, lower courts in New York have defined clear and convincing evidence as evidence which makes the existence of a fact “highly probable,” or “much more probable than its falsity.”⁵¹

4. The Right to a Neutral Factfinder

In *Lessard v. Schmidt*, the Federal District Court for the Eastern District of Wisconsin held that persons facing civil commitment have a due process right to a hearing before a neutral judge

⁴⁸ *Id.* at 432.

⁴⁹ *Id.* at 425.

⁵⁰ *Id.*

⁵¹ *Ausch v. St Paul & Marine Ins. Co.*, 511 N.Y.S.2d 919, 912-22 (2d Dep’t 1987)(approving jury instruction that used “highly probable” language to describe clear and convincing evidence); *Chenango Mut. Ins. Co. v. Charles*, 652 N.Y.S. 2d 134 (3d Dep’t 1997)(clear and convincing evidence standard requires “high probability”).

within 48 hours of detention to determine probable cause for commitment. In contrast to *Lessard*, however, the Supreme Court has said that while persons facing civil commitment are entitled to a hearing, the Due Process Clause of the Fourteenth Amendment does not require a formal hearing, nor does it require a judicial decisionmaker.

In *Parham v. J.R.* the Supreme Court held that while the risk of error inherent in a parental decision to civilly commit a child is sufficiently great that “some kind of inquiry by a ‘neutral factfinder’ should be made,” a formal hearing is not required nor must a judicial officer make the decision.⁵² The Court cited observational studies showing that most civil commitment hearings were exceedingly brief and informal on the order of 3.8 to 9.2 minutes.⁵³ To that end Chief Justice Burger remarked: “Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real,” amounting to no more than “time-consuming procedural minuets” before the patient’s eventual admission.⁵⁴ Moreover, the requirements of procedural due process are “shaped by the risk of error inherent in the truth finding process.”⁵⁵ Although medical decisions are by no means error free, the Court was satisfied that the risk of error would not be reduced by a judicial decisionmaker or an

⁵² 442 U.S. 584, 610 (1977).

⁵³ *Id.* at 610, citing Dale A. Albes & Richard A. Pasewak, *Involuntary Hospitalization: Surrender at the Courthouse*, 2 AM. J. COMMUNITY PSYCHOL. 287, 288 (1974)(reporting an average hearing duration of 9.2 minutes); Dorothy Miller & Michael Swartz, *County Lunacy Commission Hearings: Some Observations of Commitments to a State Mental Hospital*, 14 SOC. PROBS. 401, 408 (1964)(average duration 3.8 minutes); Thomas Scheff, *The Societal Reaction to Deviance: Ascriptive Elements in the Psychiatric Screening of Mental Patients in a Midwestern State*, 11 SOC. PROBS. 401, 408 (1964)(average duration 9.2 minutes).

⁵⁴ *Parham*, 442 U.S. at 610.

⁵⁵ *Id.* at 613.

adversarial hearing. Instead the Georgia civil commitment statute comported with the requirements of procedural due process insofar as admissions decisions were based on an independent medical decision followed by periodic review.⁵⁶

B. EMPIRICAL STUDIES

By the end of the 1970s, states revised their civil commitment laws to require clear and convincing evidence of mental illness and dangerousness to self or others. States also incorporated greater procedural due process safeguards into civil commitment proceedings, including notice, the right to a hearing, the right to counsel, the right to call and cross-examine witnesses, and the right to an appeal. An important purpose of these reforms was to ensure that needless deprivations of liberty were avoided; however, researchers reported that the actual practice of civil commitment proceedings departed from the standards set by courts and state legislatures. Other studies found that adherence to procedural due process protections varied across jurisdictions.

Part II.B. summarizes the second generation of studies on inpatient civil commitment hearings and procedural due process, ranging from the early 1970s through the mid-1980s. Since that time research on procedural due process and inpatient commitment has waned considerably. Part II.B. concludes with a summary of recent findings.

1. The Right to a Hearing

Given earlier empirical work on civil commitment hearings conducted pre-*Lessard*, the primary objective of subsequent research was to determine whether civil commitment hearings had become more robust, with a greater exercise of procedural due process rights in the intervening

⁵⁶ *Id.*

years. A 1976 study on due process examined the implementation of *Lessard* in Milwaukee and Dane County, Wisconsin.⁵⁷ The study revealed two distinct models of civil commitment—a *parens patriae* ethos, characterized by judicial deference to mental health professionals in determining the best interests of the patient, and a police power or due process model, characterized by adversary proceedings. The two models of civil commitment—the *parens patriae* model embraced by the Milwaukee court and the police power model implemented in Dane County—appeared to influence the rate of civil commitment. The percentage of persons civilly committed in Milwaukee was nearly four times higher than the percentage committed in Dane.⁵⁸

The nature of the proceedings also varied considerably. The average length of a civil commitment hearing in Milwaukee was 9 minutes, while the average length of a civil commitment hearing in Dane was 2 hours, with the shortest hearing lasting 45 minutes.⁵⁹ In contrast to Milwaukee, where petitioners for civil commitment were not represented by counsel, civil commitment hearings in Dane County began with the assistant district attorney presenting the case for the petitioner.⁶⁰ The district attorney usually called witnesses to show that the defendant committed recent overt acts of violence or attempted substantial physical harm to himself or others.

⁵⁷ Thomas Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 WIS. L. REV. 503 (1976); See also David Lelos, *Courtroom Observation Study of Civil Commitment*, in CIVIL COMMITMENT AND SOCIAL POLICY: AN EVALUATION OF THE MASSACHUSETTS MENTAL HEALTH REFORM ACT OF 1970 102 (1981); Carol Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW & SOC'Y REV. 629 (1977); Serena D. Steir & Kurt D. Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284 (1979).

⁵⁸ Zander, *supra* note 57 at 508.

⁵⁹ *Id.* at 518.

⁶⁰ *Id.* at 518.

In contrast to Milwaukee, attorneys in Dane usually cross-examined hospital psychiatrists regarding the necessity for involuntary hospitalization.⁶¹

2. The Right to Counsel

Studies on procedural due process frequently reported that defense attorneys were young, inexperienced and inadequately prepared to defend their clients. A Massachusetts study found that attorneys routinely avoided cross-examining hospital psychiatrists on crucial issues relating to mental illness and dangerousness.⁶² When attorneys did ask questions, they tended to limit those questions to general inquiries regarding the patient's progress to date, the type of medication administered or the patient's willingness to follow the hospital routine.⁶³ A similar study, conducted by researchers in Iowa, identified structural and nonstructural barriers to effective legal representation.⁶⁴ The attorneys who volunteered for civil commitment hearings were usually among the least experienced members of the local bar, owing in large part to the low payment they could expect to receive.⁶⁵ In

⁶¹ *Id.* at 519.

⁶² David Lelos, *Courtroom Observation Study of Civil Commitment*, in CIVIL COMMITMENT AND SOCIAL POLICY: AN EVALUATION OF THE MASSACHUSETTS MENTAL HEALTH REFORM ACT OF 1970 102 (1981).

⁶³ *Id.* at 114; *See also* Zander *supra* note 58 at 520 (describing civil commitment hearings in Milwaukee Wisconsin: “[t]here are seldom more than two or three questions on cross-examination and these questions seldom challenge the substance of the witnesses’ testimonies, but rather tend to reiterate aspects of the testimony least damaging to the defendant.”); Carol Warren, *Involuntary Commitment for Mental Disorder: The Application of California’s Lanterman-Petris-Short Act*, 11 LAW & SOC’Y REV. 629 (1977) (“In this court, most of the petitioners were represented by public defenders, who generally refrained from vigorous advocacy of their clients’ legal rights under LPS.”); *See generally*, Elliott Andalman & David L. Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey a Polemic and a Proposal*, 45 Miss. L.J. 43 (1974); Jan C. Costello, “*Why Would I Need a Lawyer?*” *Legal Advocacy for People with Mental Disabilities*, in LAW, MENTAL HEALTH AND MENTAL DISORDERS 15 (Bruce D. Sales & Daniel W. Shuman eds. 1996).

⁶⁴ Serena D. Steir & Kurt D. Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 IOWA L. REV. 1284 (1979).

⁶⁵ *Id.* at 1393.

most counties, attorneys were appointed on the day of the hearing, and in one-third of the cases surveyed, attorneys did not meet with their clients until immediately before the hearing.⁶⁶ Nor did attorneys investigate the facts alleged to justify commitment or seek alternatives to hospitalization.⁶⁷

A handful of studies also surveyed attorneys regarding the role of counsel during civil commitment proceedings. Eighty-two percent of attorneys surveyed in Iowa indicated that the role of an attorney in a civil commitment proceeding is different from representing other kinds of clients since hospitalization might be in their client's best interests (N=50).⁶⁸ In North Carolina, 65 percent of the attorneys surveyed agreed that their professional obligations in a civil commitment are unique since hospitalization may be in their client's best interests (N=58).⁶⁹ In the same way, most attorneys felt that the role of an attorney in a civil commitment proceeding should not be the same as the role of an attorney in a criminal case, which would include securing the least restrictive alternative possible for the client and avoiding confinement.⁷⁰ Still, when asked whether the role of the attorney in the civil commitment process should be secondary to that of the psychiatrist, almost two-thirds of attorneys disagreed, indicating that at least in theory, they were unwilling to defer to psychiatrists.⁷¹ In practice, however, researchers found that attorneys rarely challenged medical testimony regarding mental illness or dangerousness.⁷²

⁶⁶ *Id.* at 1395.

⁶⁷ *Id.*

⁶⁸ Stier & Stoebe, *supra* note 64 at 1397.

⁶⁹ Virginia Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C. L. REV. 1027, 1036 (1981).

⁷⁰ *Id.* at 1037.

⁷¹ *Id.* at 1038.

3. The Standard of Proof: Clear and Convincing Evidence

A small number of observational studies collected data on the evidence presented during civil commitment proceedings. For example, a study by Virginia Hiday and Stephen Markell analyzed 414 civil commitment hearings in North Carolina.⁷³ The authors found that threats of dangerous behavior (without action) were the most frequently reported dangerous behavior, followed by physical attacks, grave disablement and reports of property damage. The authors also estimated the number of cases in which the petitioner established dangerousness to others. If courts were to require proof of dangerousness based on an actual assault or a threat of assault, accompanied by action, then only 38.8 percent of the cases surveyed would meet the dangerousness requirement. If courts were to require a recent act of violence, defined as an act or threat within 10 days of the petition, only 23.9 percent of the cases surveyed would meet the dangerousness requirement.⁷⁴ In a subsequent analysis of the same data, lay examiners estimated the number of cases in which courts granted a request for inpatient commitment without at least a preponderance

⁷² *Id.* at 1039. See also Virginia Aldigé Hiday, *Representing Respondents under New Civil Commitment Statutes*, 5 L. & POL'Y. Q. 438 (1983); Virginia Aldigé Hiday, *Are Lawyers Enemies of Psychiatrists? A Survey of Civil Commitment Counsel and Judges* 140 AM. J. PSYCHIATRY 323 (1983). For a similar survey of judges in Wisconsin see Thomas Zander *supra* note 57.

⁷³ Virginia A. Hiday & Stephen J. Markell, *Components of Dangerousness: Legal Standards in Civil Commitment*, 3 INT'L J. L. & PSYCHIATRY 405 (1980); See also Virginia A. Hiday, *Application of the Dangerousness Standard in Civil Commitment*, 5 L. & HUM. BEHAV. 275 (1981).

⁷⁴ *Id.* at 413; See also Carol A.B. Warren, *Involuntary Commitment for Mental Disorder: The Application of California's Lanterman-Petris-Short Act*, 11 LAW AND SOC'Y REV. 629 (1976) (reporting data on evidence presented in civil commitment hearings under the Lanterman-Petris Short Act. Warren and her team found that while most patients were initially committed because they were a danger to themselves or others, the basis for commitment in habeas proceedings was usually "bargained down" to grave disablement. Moreover the most common pieces of evidence used to demonstrate grave disability were prior hospitalization; prior instances of refusing medication; a denial of mental illness and refusal to cooperate in the hospital.); CAROL WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* (1982).

of the evidence.⁷⁵ The authors selected the preponderance standard, rather than clear and convincing evidence, to yield a conservative appraisal of the evidence. Of the 235 cases in which requests for inpatient commitment were granted, 16 of them (6.8 percent) were judged to be based on less than a preponderance of the evidence.

4. The Right to a Neutral Factfinder

Scholars who observed civil commitment hearings in the late 1960s and 70s often described the proceedings as “perfunctory” or “a legal charade” in which judges abdicated the role as neutral factfinders to clinicians.⁷⁶ However, very few studies attempted to quantify judicial deference. In contrast to most researchers, an observational study of 454 civil commitment hearings conducted by Virginia Hiday reported that judges tended to act independently of clinical recommendations.⁷⁷ However as Hiday concedes, the study relied on conservative and somewhat crude measures of judicial deference—(i) a hearing lasting less than five minutes; (ii) failure, on the part of the judge, to question witnesses regarding mental illness and dangerousness when counsel did not; (iii) judicial acceptance of conclusory statements from psychiatrists with no supporting facts; and (iv) commitment without a preponderance of evidence, even though *Addington* calls for clear and convincing evidence. Commitment hearings were 9.4 minutes on average, longer than the 5 minute standard used in the study. Judges asked at least one question of a witnesses in 16.5% of the cases observed when psychiatrists recommended commitment. According to the author, courts

⁷⁵ Virginia Aldigé Hiday, *Court Decisions in Civil Commitment: Independence or Deference?* 4 INT’L J.L. & PSYCHIATRY 159 (1981).

⁷⁶ See, e.g., Fred Cohen, *The Function of the Attorney in the Commitment of the Mentally Ill*, 44 TEXAS L. REV. 424. (1966); Saleem A. Shah, *Some Interactions of Law and Mental Health in the Handling of Social Deviance*, 23 CATH. L. REV. 674 (1974).

⁷⁷ Virginia Aldigé Hiday, *supra* note 75.

committed respondents based on conclusory psychiatric testimony in less than 1% of cases, and less than 10% of civil commitments were based on less than a preponderance of the evidence.

Other studies examined judicial decision-making by surveying judges and estimating the impact of patient characteristics on civil commitment decisions. For example a 1986 study by Harold Bursztajn and Thomas Gutheil required judges to fill out questionnaires immediately after every civil commitment proceeding over which they presided over a four month study period.⁷⁸ In Part 1, judges were asked to rate patients on 26 variables using a 7-point scale (e.g. 1=frightening, 7= not frightening). In Part 2 judges weighed the importance of each factor. In Part 3 judges rated the ease with which the decision was reached. Thirty-five questionnaires were subjected to analysis. Judges reported three factors to have the greatest impact on their decisions—(i) whether the psychiatrist’s opinion was convincing; (ii) whether the patient would be a reliable outpatient (if not hospitalized); and (iii) whether the patient was able to take care of himself or herself. Almost all of the petitions for civil commitment were granted and in most cases, judges reported that their decisions were not difficult.

The authors hypothesize that psychiatrists only petition for commitment when they are confident that success is almost certain. Judges, in turn, “sense this preselection of committable patients, which thus dominates the decision-making process and forecloses the possibility of any outcomes other than commitment.”⁷⁹ Alternatively it may be that judges and psychiatrists rely on many of the same factors when making civil commitment decisions. A like-minded argument,

⁷⁸ Harold Bursztajn, Thomas Gutheil, et al., *Process Analysis of Judges’ Commitment Decisions: A Preliminary Empirical Study*, 143 AM. J. PSYCHIATRY 170 (1986).

⁷⁹ *Id.* at 173.

advanced by Carol Warren, maintains that judges and psychiatrists share a “commonsense model” or “topos of mental illness.”⁸⁰ She writes:

Like the defense attorneys, the judge of Metropolitan Court acquiesced to the topos of madness in his judgment that the persons processed through his court are indeed crazy and need help. He was therefore willing to facilitate their continued hospitalization when this appeared commonsensically necessary.⁸¹

In contrast to the personnel of Metropolitan Court, who were predominately white and middle to upper middle class, habeas petitioners seeking release from civil commitment were largely poor and African American or Hispanic. And, as Carol Warren writes, habeas petitioners were markedly different in their appearance. “The woman who wants to be released looks incongruous among the business suits and dresses of the court’s center stage. She shuffles to the witness stand, a towel wrapped around her head, bedroom slippers flapping on the floor, an old chenille robe.”⁸² Warren posits that the judge and psychiatrists in Metropolitan Court shared a commonsense model of mental illness built around similar indicia. Moreover these indicia are part of our culture, and as labeling theorist Thomas Scheff writes, “later psychiatric or legal models of madness merely add to, and do not cancel out, commonsense concepts.”⁸³

B. SUMMARY

When Alberta Lessard was taken to a Milwaukee mental health center in October 1972, civil commitment decisions were predicated on the “best interests” of the patient. In the years following

⁸⁰ CAROL WARREN, *THE COURT OF LAST RESORT: MENTAL ILLNESS AND THE LAW* 138 (1982).

⁸¹ *Id.* at 193-94.

⁸² *Id.* at 13.

⁸³ *Id.* at 139, citing THOMAS SCHEFF, *BEING MENTALLY ILL: A SOCIOLOGICAL THEORY* 87 (1966).

Lessard state legislatures attempted to limit intrusions on civil liberties and curb past abuses by incorporating greater substantive and procedural due process safeguards into civil commitment proceedings. However, early studies on procedural due process found that civil commitment hearings were usually too perfunctory to permit more than a cursory weighing of the evidence. Only a small number of studies on procedural due process have been conducted in recent years and most have reported similar results. A 1992 study of 100 initial commitment hearings and 183 recommitment hearings in Virginia found that the average duration of an initial civil commitment hearing was 16.5 minutes.⁸⁴ The mean duration of a recommitment hearing was only 10.5 minutes. Attorneys were also less likely to cross-examine witnesses in recommitment hearings.

In the forty years since *Lessard v. Schmidt* was decided, the delivery of mental health care in the United States has changed dramatically. During the first half of the twentieth century, large state hospitals were the primary source of care for most people with mental illnesses. By the mid-1950s, the emergence of antipsychotic medications and a rising civil libertarian ethos encouraged a shift toward community based care. While some former inpatients did well in the community, many others did not. Instead deinstitutionalization fostered a “revolving door syndrome.” Patients were routinely stabilized in hospitals and released, only to stop taking their medications, decompensate in the community and once again require rehospitalization. Part II turns to Kendra’s Law and the assisted outpatient treatment program.

II. KENDRA’S LAW

Kendra’s Law permits outpatient commitment largely on the ground that treatment noncompliance has lead to multiple hospitalizations and without a court order the person is likely to

⁸⁴ Charles D. H. Parry et al., *A Comparison of Commitment and Recommitment Hearings: Legal and Policy Implications*, 15 INT’L J. L. & PSYCHIATRY 25 (1992).

relapse becoming a danger to himself or others. The result is that the subject of an AOT order can be required to comply with outpatient treatment, even though at present, he or she does not meet the criteria for inpatient civil commitment in New York—clear and convincing evidence of mental illness and “a substantial risk of physical harm to self or others.”⁸⁵ When the State Legislature enacted Kendra’s Law in 1999, it created a host of procedural due process protections based in large part on challenges to inpatient civil commitment. As a result, Kendra’s Law includes the right to a hearing and the right to counsel. Respondents in AOT proceedings also have the right to be heard by a judge. Part II outlines the criteria for issuing AOT order, procedural due process challenges to Kendra’s Law and recent research on the AOT program.

A. MECHANICS

The process for securing an AOT order under Kendra’s Law begins with filing a petition in the supreme court of the county in which the subject of the petition is present or believed to be present.⁸⁶ A valid petition must include an affirmation or an affidavit written by a physician (other than the petitioner) who has examined the subject of the petition (the respondent) no more than 10 days before submitting the petition.⁸⁷ The petition must include a written treatment plan, and the treatment plan must include case management services or an assertive community treatment team to coordinate care.⁸⁸ The treatment plan may include any of the following services—medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; counseling

⁸⁵ N.Y. MENTAL HYG. LAW § 9.37(a)(1-2) (2006).

⁸⁶ N.Y. MENTAL HYG. LAW § 9.60 (2006).

⁸⁷ *Id.* § 9.60 (e)(3) (2006).

⁸⁸ *Id.* § 9.60 (i)(1) (2006).

and toxicology screens for patients with a history of substance abuse; individual or group therapy; day or partial day programming; educational or vocational training activities; or supervised living arrangements.⁸⁹ A court may order the respondent to self-administer psychotropic drugs, or accept the administration of such drugs by authorized personnel.⁹⁰ However, like most outpatient commitment statutes, Kendra's Law does not authorize forced administration of medication over the person's objection.

The petitioner must provide written notice of the petition to the respondent, the director of community services and the Mental Hygiene Legal Service.⁹¹ The respondent has a right to be represented by the Mental Hygiene Legal Service or private counsel during all proceedings.⁹² Upon receiving a petition, the court must set a date for the hearing within three days.⁹³ The court may issue an AOT order if the petitioner provides clear and convincing evidence that the respondent meets all of the following criteria:

- (1) he or she is 18 or older; and
- (2) suffering from a mental illness; and
- (3) unlikely to survive safely in the community without supervision, based on a clinical determination; and
- (4) has a history of treatment noncompliance that has:
 - i. been a significant factor leading to hospitalization at least twice within the last thirty-six months, or
 - ii. resulted in one or more acts of violent behavior toward self or others within the last forty-eight months, or at least a threat or attempt at

⁸⁹ *Id.* § 9.60 (a)(1) (2006).

⁹⁰ *Id.* § 9.60 (h)(i) (2006).

⁹¹ *Id.* § 9.60 (f) (2006).

⁹² *Id.* § 9.60 (g) (2006).

⁹³ *Id.* § 9.60 (h)(1) (2006).

serious physical harm to self or others within the last forty-eight months; and

- (5) is, as a result of his or her mental illness, unlikely to participate in outpatient treatment voluntarily; and
- (6) in view of his or her treatment history and current behavior, is in need of assisted outpatient treatment to prevent a relapse or deterioration, which would be likely to result in serious harm to others; and
- (7) is likely to benefit from assisted outpatient treatment.⁹⁴

Assisted outpatient treatment must also be the least restrictive form of treatment available.⁹⁵ The physician who examined the respondent and recommended outpatient treatment must testify in person during the hearing.⁹⁶ If the subject of the petition meets the criteria for AOT, the court may order assisted outpatient treatment for up to one year.⁹⁷ No more than 30 days after the court has issued an AOT order, the respondent may petition the court for a rehearing and review by a judge or jury.⁹⁸ Thirty days prior to the expiration of an AOT order, the petitioner may seek continued assisted outpatient treatment for up to one year.⁹⁹ If an AOT recipient refuses to comply with any aspect of an AOT order, and a physician determines that he or she may be in need of involuntary hospitalization, the person may be removed from the community by a police officer and detained in a hospital for up to 72 hours to determine whether he or she meets the criteria for inpatient civil commitment.¹⁰⁰

⁹⁴ *Id.* § 9.60 (c)(1)–(7) (2006).

⁹⁵ *Id.* § 9.60 (h)(4) (2006).

⁹⁶ *Id.* § 9.60 (i) (2006).

⁹⁷ *Id.* § 9.60 (j)(2) (2006).

⁹⁸ *Id.* § 9.60 (m) (2006).

⁹⁹ *Id.* § 9.60 (k)(2) (2006).

¹⁰⁰ *Id.* § 9.60 (n) (2006).

B. DUE PROCESS CHALLENGES

The Supreme Court has yet to address the constitutionality of outpatient commitment. However, in *Matter of K.L.* the highest court in New York held that Kendra's Law does not violate the Due Process Clause of the State Constitution on substantive due process grounds.¹⁰¹ K.L. argued that Kendra's Law violates due process insofar as it does not require a finding of incapacity before a court can order someone to participate in an assisted outpatient treatment plan. In doing so, K.L. relied on *Rivers v. Katz*, where the Court of Appeals held that a person must lack the capacity to make a reasoned treatment decision on his or her own before a court may order antipsychotic medications over a person's objection.¹⁰² However, Kendra's Law does not authorize medication over a person's objection. Therefore the Court of Appeals held that evidence of incapacity is not required before issuing an AOT order.

K.L. also argued that Kendra's Law violates procedural due process insofar as it allows a physician to remove noncompliant AOT recipients from the community and detain them in a hospital for up to 72 hours without notice or a hearing. When determining whether additional procedural due process safeguards are constitutionally required, *Mathews v. Eldridge* directs courts to consider three factors—(i) the private interests that will be affected; (ii) the risk of an erroneous deprivation and the probable value of additional safeguards; and (iii) the fiscal and administrative burden of additional requirements.¹⁰³ In *Matter of K.L.* the Court of Appeals held that detention in a hospital for up to 72 hours constitutes a significant deprivation of liberty, however, the patient's

¹⁰¹ In re K.L., 774 N.Y.S.2d 472 (N.Y. 2004).

¹⁰² *Id.* at 484, citing 67 N.Y.2d. 485 (N.Y. 1986).

¹⁰³ 424 U.S. 319, 335 (1976).

interests are outweighed by other factors under *Matthews*, foremost among them the low risk of error under the current statutory scheme. Before a court can issue an AOT order, it must make several findings regarding the patient's ability to survive safely in the community and his or her history of treatment noncompliance. In language echoing *Parham v. J.R.*, the Court of Appeals added: "[n]or is a court better situated than a physician to determine whether the grounds for detention—persistent noncompliance and the need for involuntary commitment—have been met. A pre-removal hearing would therefore not reduce the risk of erroneous deprivation."¹⁰⁴ Finally, the state has a significant interest in removing noncompliant patients previously found to be at risk of harming themselves or others without treatment. A pre-removal hearing would only reduce the speed with which a noncompliant patient can be evaluated.

Aside from the procedural claims raised in *Matter of K.L.*, New York courts have only heard a few procedural due process challenges to Kendra's Law. Two cases concern the evidentiary requirements for issuing an AOT order, while a third concerns the right to assistance from an expert witness. In *Matter of Jesus A.* the respondent moved to dismiss a petition for assisted outpatient treatment on the ground that neither the AOT petition nor the physician's affidavit contained facts sufficient to establish that he met the criteria for AOT.¹⁰⁵ In an affirmation, without supporting facts or documents, the physician stated "[the respondent] has a long history of noncompliance with aftercare and follow up medications which led to physically violent behavior" resulting in subsequent psychiatric hospitalizations and periods of incarceration.¹⁰⁶ In language drawn directly from the statute he added "[the respondent] has a history of lack of compliance with treatment that

¹⁰⁴ In re K.L., 774 N.Y.S.2d 472, 479 (N.Y. 2004).

¹⁰⁵ 185 Misc.2d 39 (N.Y. Sup. 2000).

¹⁰⁶ *Id.* at 39.

has resulted in one or more acts of violent behavior toward self or others.”¹⁰⁷ In a sharply worded opinion, the trial court held that the allegations contained in the physician’s affidavit were no more than conclusions, not facts, and therefore insufficient to state a claim under Kendra’s Law. Moreover, the cursory nature of the petition as well as the affirmation impeded the respondent’s right to procedural due process.

The specificity in pleading required under Kendra’s Law is not to be taken lightly.... The statutory requirement that facts be alleged to support “petitioner’s belief that the person who is the subject of the petition meets each criterion” for assisted outpatient treatment speaks not only to due process rights, by such specificity enables the respondent to prepare and interpose a defense.¹⁰⁸

The New York Court of Appeals heard a similar case several years later in *Matter of Gail R.*¹⁰⁹ The case began when the Director of Psychiatry at Elmhurst Hospital filed a petition for assisted outpatient treatment and the psychiatrist, who examined Gail R., appeared at the AOT hearing as the petitioner’s only witness. Without asking any questions of the physician, the petitioner’s counsel rested on the record and the trial court issued the AOT order over the respondent’s objection. The Court of Appeals held that by relying exclusively on the petition and affirmation of the physician who examined Gail R., the trial court effectively deprived Gail R. of her right to a hearing in which the psychiatrist’s credibility and reasons for recommending AOT could be assessed in court. As the Court of Appeals observed, petitions and affirmations are not evidence but rather pleadings which point to evidence. Therefore neither can serve as evidence to authorize AOT.¹¹⁰ Since the

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 42.

¹⁰⁹ 67 A.D.3d 808 (N.Y. Sup. 2009).

¹¹⁰ *Id.* at 811.

petitioner failed to elicit testimony from the psychiatrist who examined Gail R., and therefore failed to establish that AOT was required by clear and convincing evidence, the case should have been dismissed.

In a third case, *Dolan v. K-W*, the respondent moved to dismiss a petition for assisted outpatient treatment and asked the trial court to appoint an independent psychiatrist.¹¹¹ The case began when K.W. contested the renewal of an AOT order. The respondent argued that even though Kendra's Law does not provide for the appointment of an independent psychiatrist, courts have the authority to make that appointment under Section 35 of the Judiciary Law. Moreover "fundamental fairness" requires courts to appoint an independent psychiatrist to be compensated by the state when an indigent respondent requests a psychiatrist in an AOT proceeding.¹¹² The trial court easily dismissed the claim on the ground that Section 35 of the Judiciary Law only provides for the appointment of a psychiatrist in civil commitment proceedings to commit or retain a person in a state institution as an inpatient.

Like most outpatient commitment statutes, the procedural due process requirements in Kendra's Law are based on the requirements for inpatient civil commitment. Courts have yet to consider whether fewer procedural safeguards are required for outpatient commitment.

C. PROGRAM IMPLEMENTATION

According to the New York State Office of Mental Health, courts have issued 10,733 AOT orders since the program began in November 1999.¹¹³ Sixty-six percent of AOT recipients are male,

¹¹¹ 950 N.Y.S.2d. 419 (Sup. Ct. 2012).

¹¹² *Id.* at 421.

¹¹³ NEW YORK STATE OFFICE OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT REPORTS, <http://bi.omh.state.ny.us/aot/statistics> (last visited April 23, 2013).

48 percent of AOT recipients are white, 21 percent are African American and 30 percent are Hispanic.¹¹⁴ Three-quarters of AOT recipients have a diagnosis of schizophrenia, 19 percent have been diagnosed with bipolar disorder, and 43 percent have a co-occurring alcohol or substance abuse disorder.¹¹⁵

When the State Legislature reauthorized Kendra's Law in 2005, it also commissioned an independent evaluation of the AOT program. Researchers found that the majority of AOT cases (70 percent) are concentrated in New York City and the vast majority of AOT petitions (84 percent) are filed before the subject of the petition has been discharged from the hospital.¹¹⁶ Key informant interviews revealed that hospitals in the New York City region tend to use the AOT program as a discharge plan for hospitalized patients and voluntary agreements as a pathway out of AOT, a pattern described by researchers as the "AOT First" model.¹¹⁷ Hospitals usually cited liability concerns as an important rationale. AOT recipients also have priority for housing and scarce mental health services. In other counties, largely outside of New York City, enhanced voluntary agreements were used as a trial period before initiating a formal AOT order—the "EVS First" model. In upstate New York, EVS First was thought to be the least restrictive alternative. In downstate New York, the AOT First model was usually considered the least restrictive alternative.

The reauthorization study also included reporting on regional variations in AOT hearings across the state. In some counties one judge presided over all AOT hearings. In other counties,

¹¹⁴ NEW YORK STATE OFFICE OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT REPORTS, <http://bi.omh.state.ny.us/aot/characteristics> (last visited April 23, 2013).

¹¹⁵ *Id.*

¹¹⁶ Martin S. Swartz, Henry J. Steadman, & John Monahan, NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION, 6, <http://www.omh.ny.gov> (2009) (last visited Sept. 2, 2012).

¹¹⁷ *Id.* at 5.

AOT hearings were rotated among several judges. Some counties reported that they do not require the treating psychiatrist to testify in court if the respondent does not contest the petition, even though the letter of Kendra's Law clearly states that a physician who recommends AOT must testify in person, without distinction between contested and uncontested hearings. Through interviews with MHLS attorneys, Pamela Robbins and colleagues found that perceptions of attorney role also appear to vary by region: "In some counties, the attorneys viewed AOT as the least restrictive alternative to hospitalization and as a gateway to receipt of needed community services."¹¹⁸ In other counties, "attorneys viewed their role as adversarial with respect to the AOT petitioners, representing their clients' own wishes rather than the client's 'best interests' per se, as defined by clinicians or family members."¹¹⁹

Researchers surveyed 211 AOT recipients regarding their perceptions of coercion and procedural justice in the AOT program. The study measured coercion on 5-item scale, with responses ranging from 1 to 5, from strongly agree to strongly disagree. Sample items included: "It was my idea to get treatment" and "I felt free to do what I wanted about getting treatment."¹²⁰ AOT recipients reported moderate levels of coercion ($M=2.76$; $SD=.96$). AOT recipients were also asked to report their perceptions of procedural justice on 6-item scale. For example: "When you received the AOT court order, did you have enough opportunity to tell the court or treatment provider what you think they need to hear about your personal and legal situation?" "When you received the AOT

¹¹⁸ Pamela Clark Robbins, *Regional Differences in New York's Assisted Outpatient Treatment Program*, 61 PSYCHIATRIC SERVICES 974 (2010).

¹¹⁹ *Id.*

¹²⁰ Swartz et al. *supra* note 3 at 36.

court order, did they treat you respectfully?”¹²¹ “Are you satisfied with how they treat you and deal with your case?”¹²² Responses were measured on a 3-point scale—ranging from “not at all” to “somewhat” and “definitely”—with higher scores reflecting greater perceived procedural justice. When compared to their counterparts who had not recently participated in the AOT program, current AOT recipients had more favorable perceptions of procedural justice ($M=1.96$ vs. $SD=1.80$).

D. SUMMARY

The 2005 reauthorization study provided valuable information on the assisted outpatient treatment program. We know that most petitions for assisted outpatient treatment are concentrated in New York City and hospitals tend to use AOT as a discharge plan. We also know that at least some AOT recipients perceive the program to be non-coercive, and at least when compared to their counterparts, AOT recipients have favorable perceptions of procedural justice, including perhaps a favorable perception of AOT hearings.

While the reauthorization study greatly advanced our understanding of the AOT program, it also left other questions unanswered, for example—how do courts determine whether someone meets the criteria for AOT and how much do they rely on clinical recommendations? Moreover what constitutes “clear and convincing evidence” that a person meets the criteria for assisted outpatient treatment as required by law? The reauthorization study reported broad upstate-downstate variations in perceptions of attorney role, although other researchers argue that even within the New York City region, attorneys who represent people with mental illnesses in AOT

¹²¹ *Id.* at 37.

¹²² Email from Karli Keator, researcher, to author (March 25, 2013) (on file with author).

proceedings have very different views of client advocacy.¹²³ In light of this controversy, this study surveyed MHLS attorneys in the First and Second Department on their perceptions of the AOT program, AOT hearings and their professional obligations to their clients.

III. METHODS

A. DATA COLLECTION

1. Courtroom Observation

Data collection for this study began by observing AOT hearings in Manhattan, the Bronx, Brooklyn, Queens and Staten Island. Data collection included hearing location, hearing duration, arguments raised by the attorney for the petitioner, defenses raised by counsel for the respondent and the decision rendered by the judge. All items were recorded on a 35-item checklist designed for the study (Appendix 1). The checklist was pretested on 20 AOT hearings in the Bronx and revised before data collection began in June 2010. One hundred eighty five hearings were observed by the author between June 2010 and September 2011.¹²⁴

2. Participant Interviews

Following the courtroom observation period, judges and attorneys were asked to participate in a semi-structured interview conducted by the author. Interview participants were identified through courtroom observation, the New York State Office of Court Administration, the Mental Hygiene Legal Service, and snowball sampling. Inclusion criteria for the study required judges and

¹²³ Jeffrey Swanson, *What Would Mary Douglass Do? A Commentary on Kaban et al., "Cultural Cognition and Public Policy: The Case of Outpatient Commitment Laws"* 34 L. & HUM. BEHAV. 176 (2010).

¹²⁴ Hearing observation took place over 41 hearing days.

attorneys to have participated in at least 10 AOT hearings in order to be eligible for an interview. All who responded were eligible. Inclusion criteria were ascertained through self report.

Interviews were conducted in person or by telephone if a face-to-meeting meeting was infeasible. Judge and attorney interview questions were pretested on 5 attorneys and revised before participant interviews began in October 2010. Interviews were conducted through November 2011 and generally lasted 45 to 60 minutes. MHLS attorneys in the First and Second Department were asked to describe their preparation for AOT hearings, their perceptions of AOT hearings and their professional obligations to their clients. Judges were asked to describe their preparation for AOT hearings, how they define clear and convincing evidence, and how they determine whether someone meets the criteria for AOT (Appendix 2). Interviews were audio recorded with the consent of the participant and transcribed in full. If participants declined to be recorded, the author took notes by hand, using quotation marks to identify verbatim responses. AOT recipients and psychiatrists were not interviewed due to restrictions imposed by the New York City Health and Hospitals Corporation. This study was approved by the Harvard University Committee on the Use of Human Subjects.

B. DATA ANALYSIS

Interview transcripts and hearing observations were analyzed using thematic content analysis. Thematic content analysis enables researchers to translate qualitative information into quantitative data by identifying recurring patterns or “themes” within a qualitative data set.¹²⁵ Data analysis began by developing a preliminary set of codes and coding a sample of AOT hearing observations. After refining, adding, subtracting and splitting potential codes, the author developed a final coding manual and coded each AOT hearing observation.

¹²⁵ RICHARD E. BOYATZIS, TRANSFORMING QUALITATIVE INFORMATION, 14 (1998).

AOT hearing observations were analyzed for patterns in the evidence presented by petitioners and arguments raised by defense attorneys. In contrast to previous research in this area, this study did not attempt to determine the fraction of cases in which the petitioner presented clear and convincing evidence as determined by an external examiner. Instead the study identified factors constitutive of clear and convincing evidence by isolating cases in which AOT petitions were granted and systematically identifying themes in the evidence presented by petitioners.

IV. RESULTS

A. AOT HEARINGS

1. Uncontested Hearings

Of the 185 AOT hearings observed by the author, the majority were uncontested (73.5 percent) (Table 1). Uncontested hearings follow a predictable pattern. On the day of the hearing, the petitioner will call the psychiatrist to the stand. The petitioner will ask the respondent to stipulate to the psychiatrist's qualifications as an expert in the field of psychiatry, and after laying a foundation, the petitioner will ask the court to admit the respondent's medical records into evidence. The petitioner will then ask the psychiatrist a few simple questions: (1) "Are you familiar with the respondent?" (2) "Have you examined the respondent in connection with AOT?" (3) "In your opinion does the respondent meet the criteria for the assisted outpatient treatment program?" When hearings are uncontested, psychiatrists usually provide a simple yes or no to most questions and list the elements of the treatment plan for the record.

In all of the hearings observed, an attorney from the Mental Hygiene Legal Service represented the respondent. If the hearing was uncontested, the respondent's attorney did not cross-examine the psychiatrist. Instead he or she asked a few simple questions of the client on direct examination: (1) "Has the treatment plan been explained to you?" (2) "Do you understand what you

are required to do?” (3) “Do you understand what will happen if you do not comply with the plan?” Respondents usually indicated that if they did not comply with treatment, they could be taken back to the hospital. Respondents testified in 36 uncontested hearings (26.5 percent). Across all boroughs the average duration of an uncontested hearing was 2.67 minutes ($SD = 2.59$) (Table 1).

2. Contested Hearings

Of the 185 AOT hearings observed, 49 (26.5 percent) were contested (Table 1). Of those contested hearings, 42 were renewal hearings (85.7 percent). In 7 contested hearings, the petitioner presented an initial application for assisted outpatient treatment (14.2 percent). Across all boroughs, the average duration of a contested AOT hearing was 18.29 minutes ($SD = 11.02$) with the longest hearing lasting 49 minutes and the shortest contested hearing lasting only 4 minutes. Respondents testified in 37 contested hearings (75.5 percent).

a. Evidence

Table 2 describes the evidence presented in 48 hearings where a petition for assisted outpatient treatment was contested and granted. The evidence presented in these cases suggests that courts are persuaded by the following factors: (1) a history of treatment noncompliance (2) clinical testimony regarding poor insight into mental illness or the need for treatment; (3) a history of harm to self or others; and (4) evidence of substance abuse. Nothing in this study should be interpreted to suggest that evidence in each of these categories is necessary or sufficient to establish clear and convincing evidence. Rather the tendency to provide evidence of this kind suggests that these facts tend to establish clear and convincing evidence in the mind of the factfinder.

In a large majority of cases (75 percent) the AOT Team psychiatrist testified that the respondent either had not, or would not, comply with treatment, either because he or she failed to attend several days of a court ordered day program or refused to take one or more court ordered

medications. In a handful of cases, respondents simply stated that they would not take their medications. In other cases, psychiatrists testified that while the respondent had been compliant with his or her medications for a few weeks or a few months, the respondent also had a long history of treatment noncompliance. A few weeks of compliance could not guarantee that the respondent would continue to do so in the future.

In a little more than half of the contested cases observed (52.1 percent) a psychiatrist testified that the respondent lacked insight into his or her mental illness or the need for treatment. Psychiatrists often testified that the respondent did not believe he has a mental illness, the respondent acknowledges the symptoms of a mental illness, but attributes them to something other than mental illness, or the respondent acknowledges the benefits of medication, but continues to believe that he does not have a mental illness. In 41 percent of the cases observed, a psychiatrist testified that the respondent was at risk of harming himself or others. Evidence in this category included a history of aggression, threats to harm others, suicide attempts and suicidal ideation. In a sizeable number of cases (27.1 percent) a psychiatrist testified that the respondent's clinical presentation became worse in the presence of cannabis or alcohol. Part IV.B.2 below discusses subjective factors influencing AOT decisions such as the credibility of an expert witness and the quality of the testimony from the respondent.

TABLE 1. SUMMARY STATISTICS: CONTESTED AND UNCONTESTED AOT HEARINGS (N=185)

	MANHATTAN	BRONX	QUEENS	BROOKLYN	STATEN ISLAND	TOTAL
CONTESTED HEARINGS	n = 16 n (%)	n = 4 n (%)	n = 14 n (%)	n = 12 n (%)	n = 3 n (%)	n = 49 n (%)
No. of Hearings Observed	16 (32.7)	4 (8.2)	14 (28.6)	12 (24.5)	3 (6.1)	49
Location						
Hospital	16 (32.7)	4 (8.2)	0	0	0	20 (40.8)
Courthouse	0	0	14 (28.6)	12 (24.6)	3 (6.1)	29 (59.2)
Initial Hearing	1 (2.0)	1 (2)	2 (4.1)	3 (6.1)	0	7 (14.3)
Renewal Hearing	14* (93.8)	3 (75)	12 (85.7)	9 (75)	3 (100)	41 (84.7)
Decision	15 (93.8)	4 (100)	14 (100)	12 (100)	3 (100)	48 (98)
Grant	5 (31.3)	2 (50)	3 (21.4)	0	0	8 (16.3)
With revisions	10 (62.5)	3 (75)	11 (78.6)	12 (100)	3 (100)	40 (81.6)
Without revisions	1 (6.3)	0	0	0	0	1 (2.0)
Deny	5 (31.3)	0	2 (14.3)	12 (100)	0	19 (38.8)
Basis Stated	5 (31.3)	2 (50)	2 (14.3)	12 (100)	0	21 (42.9)
Hearing Duration	14.69 (SD =11.03)	20.75 (SD =19.72)	19.07 (SD =9.56)	21.67 (SD =12.37)	17 (SD =12.37)	18.29 (SD =11.02)
UNCONTESTED HEARINGS	n = 66 n (%)	n = 31 n (%)	n = 8 n (%)	n = 30 n (%)	n = 1 n (%)	n = 136 n (%)
No. of Hearings Observed	66 (48.5)	31 (22.8)	8 (5.9)	30 (22.1)	1 (0.7)	136
Location						
Hospital	66 (100)	31 (100)	5 (62.5)	0	0	102 (75)
Courthouse	0	0	3 (37.5)	30 (100)	1 (100)	34 (25)
Initial Hearing	7 (10.6)	1 (3.2)	5 (62.5)	2 (6.7)	0	15 (11)
Renewal Hearing	21 (31.8)	20 (64.5)	3 (37.5)	14 (46.7)	1 (100)	59 (43.4)
Not Specified	34 (56)	10 (32.2)	0	14 (46.7)	0	61 (44.9)
Not Recorded	4 (6.0)	0	0	2 (6.7)	0	1 (0.73)
Decision						
Grant						
With revisions	66 (100)	31 (100)	8 (100)	30 (100)	1 (100)	136 (100)
Without revisions	0	0	0	0	0	0
Deny	0	0	0	0	0	0
Basis Stated	0	0	0	30 (100)	0	30 (22.6)
Hearing Duration	1.88 (SD = 1.60)	2.81 (SD=1.45)	4.75 (SD=1.04)	3.70 (SD=4.31)	6.00 (SD=4.31)	2.67 (SD=2.59)

* Missing Data

**TABLE 2. EVIDENCE PRESENTED IN CONTESTED AOT HEARINGS
WHERE ORDER WAS GRANTED (N=48)**

	MANHATTAN	BRONX	QUEENS	BROOKLYN	STATEN ISLAND	TOTAL
EVIDENCE FOR AOT	n = 15 n (%)	n = 4 n (%)	n = 14 n (%)	n = 12 n (%)	n = 3 n (%)	n = 48 n (%)
Diagnosis						
Schizophrenia	8 (53)	1 (25)	6 (42.9)	3 (25)	2 (66.7)	20 (40.8)
Schizoaffective Disorder	3 (20.0)	1 (25)	6 (42.9)	4 (33.3)	1 (33.3)	15 (30.6)
Substance Abuse Disorder	0	1 (25)	6 (42.9)	4 (33.3)	0	11 (22.4)
Bipolar Disorder	2 (13.0)	0	2 (12.3)	5 (41.7)	0	9 (18.8)
Depression	1 (6.7)	2 (50)	0	0	0	0
Personality Disorder	0	0	1 (7.14)	0	0	1 (2.08)
Risk Factors Indicating Need for AOT						
Lacks stable residence	3 (20.0)	0	1 (7.14)	0	2 (66.7)	6 (12.5)
Poor self care	1 (6.7)	0	1 (7.14)	0	0	2 (4.2)
Poor insight	7 (46.7)	1 (25)	4 (28.6)	10 (83.3)	2 (66.7)	25 (52.1)
Substance abuse	2 (13.3)	1 (25)	4 (28.6)	4 (33.3)	2 (66.7)	13 (27.1)
Medication noncompliant	10 (66.7)	4 (100)	12 (85.7)	7 (58.3)	3 (100)	36 (75)
Removal order	1 (6.7)	0	2 (12.3)	1 (8.3)	0	5 (10.4)
Hospitalization during AOT	2 (13.0)	0	5 (35.7)	0	0	7 (14.6)
Harm to others	4 (26.7)	3 (75)	3 (21.4)	2 (16.7)	1 (33.3)	13 (27.1)
Harm to self	3 (20.0)	0	2 (12.3)	2 (16.7)	0	7 (25)
Likely Benefit						
Previous benefit	5 (33.3)	1 (25)	4 (28.6)	4 (33.3)	0	15 (31.3)
Maintain respondent in the community	1 (6.7)	0	5 (35.7)	2 (16.7)	0	8 (16.7)
Improve treatment compliance	4 (26.7)	2 (50)	5 (35.7)	5 (41.7)	0	16 (33.3)
Improve coping skills	0	0	0	4 (33.3)	0	4 (8.3)
Improve insight	0	0	0	6 (50)	0	6 (12.5)
Witness affirms without stating facts	10 (66.7)	1 (25)	6 (42.9)	3 (25)	3 (100)	23 (47.1)
Least Restrictive Alternative						
Maintain respondent in the community	0	0	3 (21.4)	0	0	3 (6.25)
Witness affirms without stating facts	15 (100)	4 (100)	7 (50)	12 (100)	3 (100)	41 (85.4)
Other Testimony						
Mostly compliant with AOT	3 (20)	0	1 (7.14)	2 (16.7)	0	6 (12.5)

a. Defense Counsel Activity

Table 3 summarizes defense counsel activity in 49 hearings where a petition for assisted outpatient treatment was either granted or denied. Very few attorneys argued that their clients were not mentally ill (8.16 percent). Instead attorneys were more likely to challenge the petitioner's assertion that their clients were unlikely to participate in outpatient treatment voluntarily (61.2

percent). To that end, attorneys cross-examined psychiatrists with questions designed to elicit evidence that their clients were compliant with court orders, except perhaps for a few missed doses of medication or a few missed appointments with their treatment team (14.3 percent). Nor was it uncommon for attorneys to point to the side effects of a particular medication as a reason for noncompliance (18.4 percent).

TABLE 3. DEFENSE COUNSEL ACTIVITY CONTESTED AOT HEARINGS (N=49)

	MANHATTAN n = 16 n (%)	BRONX n = 4 n (%)	QUEENS n = 14 n (%)	BROOKLYN n = 12 n (%)	STATEN ISLAND n = 3 n (%)	TOTAL n = 49 n (%)
AOT CRITERIA						
Mental illness	0	1 (25)	2 (14.3)	1 (14.3)	0	4 (8.16)
Unlikely to survive safely in the community	5 (31.25)	4 (100)	6 (42.9)	5 (41.7)	0	20 (40.8)
Noncompliance led to 2 or more hospitalizations	1 (6.25)	0	0	0	0	1 (2)
Noncompliance led to 1 or more acts of violence	0	0	0	0	0	0
Unlikely to participate in treatment voluntarily	9 (56.25)	1 (25)	7 (50)	11 (91.7)	2 (66.7)	30 (61.2)
Needs AOT to prevent relapse or deterioration	10 (62.5)	3 (75)	6 (42.9)	6 (50)	1 (33.3)	26 (53.1)
Likely benefit	1 (6.25)	2 (50)	4 (28.6)	0	0	7 (14.3)
Least restrictive alternative	3 (18.8)	0	4 (28.6)	5 (41.7)	0	12 (24.5)
OTHER ARGUMENTS						
Compliant with AOT	2 (12.5)	0	2 (50)	3 (25)	0	7 (14.3)
Evidence of good mental health	0	1 (25)	5 (35.7)	1 (14.3)	0	7 (14.3)
Medication side effects	3 (18.8)	0	2 (50)	4 (33.3)	0	9 (18.4)
Medication adjustment	2 (12.5)	0	0	2 (16.7)	0	4 (8.16)
Insufficient evaluation	0	0	1 (7.14)	1 (14.3)	0	2 (4.08)
AOT interferes with work or school	0	1 (25)	0	1 (14.3)	0	2 (4.08)

In almost half of the contested cases observed, attorneys challenged the petitioner's claim that their clients were unlikely to survive safely in the community (40.8 percent) or needed AOT in order to prevent a relapse which would be likely to result in serious harm to others (53.1 percent). Attorneys usually presented evidence that their clients were able to stay out of the hospital, work or attend school. In 56.4 percent of the cases observed, a psychiatrist testified that the respondent

lacked insight into his or her mental illness or the need for treatment. In most of those cases, attorneys responded by asking their clients to describe the symptoms of their illness and their plans to continue treatment. For example:

ATTORNEY: Do you believe you have a mental illness?

RESPONDENT: Yes.

ATTORNEY: And what is the diagnosis that you have been given?

RESPONDENT: Well, schizophrenia and they say bipolar disorder...

ATTORNEY: Okay. What sort of symptoms do you suffer from when you are not well?

RESPONDENT: Well, I get shaky. I get frustrated. Sometimes I get agitated. I start to walk out of the house and start to, you know, wander around... I just stop being myself. I start thinking differently....

ATTORNEY: When you are having problems with the medications, do you ever just stop taking them now?

RESPONDENT: No. I talk to my counselor. I talk to my ICM worker....¹²⁶

b. Disposition

Courts granted the petitioner's request for assisted outpatient treatment in 48 of the 49 contested cases observed (98 percent). In 9 of the 48 cases, courts granted the petitioner's request, but reduced the duration of the treatment order by 56 percent from 6 months to 3.3 months on average. Judges reduced the length of an AOT order for a few reasons—(i) aside from an unauthorized absence or an unauthorized disappearance, the respondent had been compliant with treatment, (ii) the respondent acknowledged his or her mental illness, but disliked his or her psychiatrist or objected to visits from a case manager; and (iii) the respondent complained about the side effects of his or her medications—including substantial weight gain, nausea, and fatigue—and the side effects of these medications interfered with work or school.

In 1 of the 49 contested AOT cases observed, the court denied the AOT petition outright. The petitioner asked the court to renew the respondent's AOT order for an additional 6 months.

¹²⁶ Transcript of AOT Hearing (August 4, 2010)(on file with author).

According to the psychiatrist, the respondent told him that he does not have a mental illness. In his opinion, the respondent would not take his medications without a court order, although he had done well in the AOT program. Without AOT, the respondent's prognosis would be poor due to bipolar disorder. The respondent was able to clarify his statements in court. As he spoke, the judge nodded sympathetically:

RESPONDENT: He asked me, "why are you taking lithium?" I said that it's part of the court order. If you had asked me "do I have a problem?" I would have said "yeah."

During her cross-examination of the psychiatrist, defense counsel was also able to elicit favorable testimony on her client's behalf. The respondent was able to stay out of the hospital for 12 months, even though he was not taking his medications. The respondent also added that he would take his medications without a court order: "The people I live with would make sure I take it. I don't think I need AOT."

B. INTERVIEWS

When participant interviews began in October 2010, approximately 35 judges presided over AOT hearings in Manhattan, the Bronx, Brooklyn, Queens and Staten Island and 30 attorneys from the Mental Hygiene Legal Service (MHLS) represented the respondents. All were invited to participate in an interview. Of them 13 judges (37 percent) and 20 attorneys (66 percent) met the inclusion criteria for the study and agreed to be interviewed. The study sample included 10 MHLS attorneys and 7 judges from the First Judicial Department and 10 MHLS attorneys and 6 judges from the Second Judicial Department. Defense attorneys were predominately white and female with 5.9 years of experience representing people in AOT hearings on average. Judges were predominately white and male with 4.4 years of presiding over AOT hearings on average. Part IV.B.1. below presents key themes emerging attorney interviews followed by interviews with judges in Part IV.B.2.

1. Attorneys

Defense attorneys underscored their professional obligation to advocate for their clients zealously and to the full extent of the law. However, attorneys also reported that AOT hearings can be hard to win for a few reasons, ranging from facts adverse to their clients to a dearth of favorable expert testimony and judicial attitudes toward the mentally ill.

a. Impediments to Effective Advocacy

i. History of Treatment Noncompliance

AOT Recipients tend to have a long history of treatment noncompliance. According to the New York State Office of Mental Health, the vast majority of AOT recipients have had at least one psychiatric hospitalization prior to AOT (70 percent) with 3.4 psychiatric hospitalizations on average.¹²⁷ A smaller fraction have also been incarcerated (15 percent) or homeless (18 percent).¹²⁸ According to some attorneys courts tend to assume that if their clients are doing well, and he or she has not been hospitalized for a year, AOT must be the reason. A principal attorney in the Second Department remarked: “The attitude is ‘this program is working. See? The person was hospitalized five times and now AOT comes in and they haven’t been hospitalized since, so obviously they need AOT.’ That’s how the connection is drawn” (Attorney 4). The same attorney explained that his office spends a lot of time trying to break that connection by demonstrating that their clients have developed insight into the seriousness of their mental illness and the need for treatment. “Really, practically, the only way you can expect to win a hearing is if your client is going to get up and testify

¹²⁷NEW YORK STATE OFFICE OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT REPORTS, <http://bi.omh.state.ny.us/aot/statistics> (last visited April 23, 2013).

¹²⁸ *Id.*

with insight that they know they have a mental illness and they know they need the medication” (Attorney 4).

ii. Expert Testimony

Many attorneys (5 of 19) noted that AOT hearings are particularly difficult to win without expert testimony. Part of the problem stems from the criteria for issuing an AOT order. For example, section 9.60(5) of Kendra’s Law requires clear and convincing evidence that “as a result of his or her mental illness” the respondent is unlikely to participate in outpatient treatment voluntarily.¹²⁹ Section 9.60(1) requires evidence that the respondent is “unlikely to survive safely in the community.”¹³⁰ As one attorney remarked “That’s pure opinion. There’s no fact...[Judge X] is always going to side with the doctor and that’s part of the problem” (Attorney 4). Attorney 4 explained that the only way to win an AOT hearing before Judge X is to win on a technicality, for example, the patient was hospitalized three times in the past three years, but not within the required time frame. In other boroughs, attorneys doubted that expert testimony would help, since independent clinical witnesses are also reluctant to release people with mental illnesses into the community without supervision. Although in theory, defense attorneys could invite a court-appointed psychiatrist to testify for them, appointed psychiatrists are employed by the Office of Court Administration with a professional responsibilities to the court, rather than MHLS clients. And as one attorney put it, “[y]ou can’t doctor shop” (Attorney 10). Instead MHLS attorneys are required to select expert witnesses from a list, whether that particular clinician would be a good fit for their client or not.

¹²⁹ N.Y. MENTAL HYG. LAW § 9.60(5) (2006).

¹³⁰ *Id.* § 9.60(1) (2006).

Attorneys also indicated that judicial reliance on expert testimony may be faulty in one further respect—in most cases, the psychiatrist who has been designated to testify on behalf of the AOT Team has not provided services to the respondent and has had no other interaction with the respondent aside from the AOT evaluation. The average AOT evaluation lasts from 15 or 30 minutes to an hour. AOT evaluations are also few and far between—once before AOT recipients are discharged from the hospital into the community and again when the Director of Community Services requests a renewal order. As a result, at least some attorneys (4 of 20) felt that testifying psychiatrists don't always know as much as they should about their clients, how they have fared in the community since the initial court order or the day to day requirements of the treatment plan.

iii. Judicial Attitudes Toward the Mentally Ill

Many attorneys (5 of 20) indicated that judicial attitudes toward people with mental illnesses and the assisted outpatient treatment program also make it difficult to win cases. As one attorney said, judges tend to think that people with mental illnesses are all “crazy” and “nuts” because “every once in a while some guy goes on a rampage and does something terrible” (Attorney 1). Nor do judges see much downside in granting AOTs. “They figure. What is the harm? The person is going to be provided with services. It's protecting the community should anything happen” (Attorney 13).

A handful of attorneys in both Judicial Departments also reported that judges do not credit their client's testimony (3 of 20):

ATTORNEY: One of the other major problems with AOT is that the client's testimony means *nothing*. It's not given *any* credit or *any* weight.

INTERVIEWER: How can you tell that the judge is not taking that into account?

ATTORNEY: Because they'll say things off the record about it which you don't see in the transcripts or after they'll ask us. “Did that really happen?” or “Is what they're saying really true?... I mean we see the same judge every week so we're friendly with them, you know?...[A] hearing is not necessarily always the real deal. Like it's not always what really happened because it's about fighting as to what evidence gets in or not. So judges

know that they're not hearing the whole story most of the time. Usually they'll ask you after "What really happened?"

iv. Medicalization of Deviance

Some attorneys felt that their clients are held to a high standard since the people around them—usually family members or providers—are likely to interpret any problems they might have as a symptom of mental illness. "If a sibling gets into a fight with another sibling, that can be deemed a symptom of decompensation," one attorney said (Attorney 7). Moreover "it's not unusual for people to carry weapons or feel the need to carry weapons because of gang violence," but if someone in the AOT program is carrying a weapon, "red flags go up" (Attorney 7). In the same way, attorneys noted that families sometimes call 911 inappropriately.

b. Attorney Role: Zealous Advocacy or Best Interests?

The vast majority of petitions for assisted outpatient treatment are uncontested, but when their clients ask them to challenge AOT, attorneys uniformly underscored their professional obligation to do so zealously and without taking the position that AOT is in their client's "best interests" (20 of 20). "For myself and I know most of the people at MHLS, I mean our belief is that we're representing what our client wants regardless of whether we might personally feel that something else might be better for them" (Attorney 19). Nor were there noticeable differences across boroughs.

When their clients object to AOT, attorneys also reported that an important part of their job involves counseling their clients on the likelihood of success and negotiating a compromise with the AOT Team.

I'm very honest with my clients. I try to work with them. I will meet with them alone and say "This is your history. This is all going to come out in court...If you feel strongly that the medication doesn't work for you, we'll tell the judge" But I work with them. We go through it—the pros and the cons...Sometimes Dr. [X]

wants 12 months. They don't want anything. When we meet in the AOT exams we negotiate. (Attorney 10).

Attorneys felt strongly that they have a professional obligation to advance the best possible arguments on behalf of their clients, although a small number conceded they are more restrained in their arguments when the facts are not on their side (3 of 20). As one attorney said “I need to maintain my credibility for the one million other clients I handle” (Attorney 5). Others are demoralized by the daily toll of arguing zealously for their clients, knowing full well that the judge almost never rules in their favor: “I just feel it's a losing battle and I'm there as a shadow, my client's shadow” (Attorney 9).

2. JUDGES

a. Deciding AOT Hearings

By law a person seeking assisted outpatient treatment must submit a petition to the supreme court of the county in which the respondent is located or believed to be located. However, nearly all judges (12 of 13) reported that they usually do not read AOT petitions before the hearing. Judges stated that they usually don't read petitions in advance for a few reasons—(i) most of the petition is a pro forma recitation of the criteria for AOT; (ii) AOT attorneys usually elicit pertinent facts from their witnesses on direct examination; (iii) if the respondent does not appear in court, the hearing may be adjourned; and (iv) by law the date of the hearing must be no more than 3 days from the day the petition was received by the court, leaving judges with little time for reading. Instead judges usually read petitions on the bench while listening to testimony.

Judges also indicated that AOT decisions are largely based on evidence presented during the hearing. Reported influences on AOT decision-making were centered around four themes—(i) the heavy weight attached to expert testimony; (ii) the possibility of harm to others; (iii) the endless revolving door of hospital admissions; and (iv) the liberty interests of AOT recipients.

i. Expert Testimony

Many judges reported that they rely on clinical recommendations particularly when the clinician has appeared before them in prior hearings and established a reputation for credibility. “This is a field, and I’d like to think all the other judges have said this too, or admitted this, that quite honestly, it’s heavily weighted in favor of medical testimony,” one judge explained (Judge 8). To that end expert witnesses generally perform two functions during AOT hearings. The first is simply to educate the court on unfamiliar diagnoses and medications. The second is to provide a clinical recommendation regarding the necessity of assisted outpatient treatment. In doing so judges are particularly attuned to how doctors answer questions on cross examination and whether their answers are credible. As one judge commented: “I rely heavily on what the doctor says, meaning everything the doctor says, so if this is a contested AOT obviously that includes the doctor’s responses to cross-examination questions” (Judge 8).

Some judges (3 of 13) explained that while they are willing to modify AOT orders based on the “legitimate concerns” of AOT patients, they are reluctant to deny an AOT petition outright unless an expert testifies on his or her behalf. As one judge put it:

I am not a mental health professional so if a mental health professional testifies that this is what is needed I have no basis to say “No.” When I actually get a presentation from the other side I take it seriously...But I need a basis (Judge 9).

When asked whether testimony from the respondent would provide such a basis, the judge responded: “It rarely makes a difference. Sometimes it does and sometimes what I’ve done is modify the proposed order to meet the legitimate concerns of the patient” if, for example, an AOT patient raises a reasonable concern regarding the side effects of a medication or a particular provider (Judge 9). Or as another judge remarked, “If the patient happens to testify, there may be elements in what the doctor says, but I really rely very, very heavily on what the doctor says” (Judge 8).

ii. Harm to Others

Without expert testimony, judges were unwilling to deny a petition for AOT owing in large part to their fear that AOT recipients would harm themselves or importantly, harm others. “You don’t want to have something where a person well-meaning is out there and loses it and does something that will harm himself or God forbid, harm someone else” (Judge 11). Or as another judge said: “Reality? Do you know what the judge’s priority criterion is? They don’t want to be on the front page of tomorrow’s newspaper—Judge Releases Madman Who Slays 29 People” (Judge 2). In the same way judges frequently referred to the violent origins of Kendra’s Law (5 of 20). As one judge remarked, in reference to Andrew Goldstein, the man who pushed Kendra Webdale in front of a train, the Office of Mental Health allowed “someone that’s arguably a loaded gun into the population” (Judge 13). Or as another judge said, referring to the AOT program, “the only justification is public safety. You don’t want somebody pushed off the subway platform again” (Judge 9).

iii. The Revolving Door of Hospital Admissions

When patients argue that they no longer need AOT, judges also suspected that the symptoms of mental illness might prevent the person from recognizing the need for treatment. Quite often their perceptions were based on their experience with AOT cases as well as non-AOT cases, for example—guardianships, retention hearings, and applications for medication over objection.

I’ve learned from many years of sitting at these hearings including the hearings of people who have to be rehospitalized and retained, that when people take their medication they start to feel well. They start to function and then they believe “I’m well. I don’t have to take the medication anymore,” and they end up back warehoused in the hospital retained for sometimes months at a time (Judge 11).

In the same way, a handful of judges (3 of 13) recounted instances in which they released a person from the hospital only to find out that the person had been rehospitalized. As one judge said: “I might get them out and you see the history, back in and out and there are several commitments in between. So it’s a frustration. I don’t have any easy answer. I’m not a doctor. I’m not a psychiatrist. I just don’t have an easy answer” (Judge 6). A sizeable number of judges (4 of 13) wondered whether hospitals were discharging people with mental illnesses prematurely.

Others felt that after years in and out of the mental health system, the respondent “knows what to say at the appropriate time” notwithstanding his or her mental illness, making it enormously difficult for judges to determine whether respondents are being truthful when they declare their intention to continue outpatient treatment voluntarily (Judge 7). In other instances the respondent’s medical history and incoherent testimony corroborates the need for AOT.

iv. Liberty Interests

To a lesser extent judges also voiced concerns regarding the liberty interests of AOT recipients (3 of 13). For example some judges noted that while compulsory outpatient treatment is certainly less onerous than hospitalization, the program imposes a substantial restriction on the liberty interests of AOT recipients since most are required to participate in court ordered programs at least once or twice a week. In the same way, another judge wondered whether patients actually benefit from long term participation in the AOT program. The same judge felt that the assisted outpatient treatment program was designed to protect hospitals from a lawsuit should a former inpatient injure a member of the public. Treatment plans, designed without due attention to the needs of the patient, and prom forma petitions in which petitioners merely “plug in” facts reflect the “c.y.a.” origin of the program (Judge 7).

b. Clear and Convincing Evidence

The standard of proof for an assisted outpatient treatment order is clear and convincing evidence. New York courts have defined clear and convincing evidence as evidence which makes the existence of a fact “highly probable.”¹³¹ Only a few judges defined clear and convincing evidence in similar terms (2 of 13). Most defined clear and convincing evidence broadly as more than a preponderance of the evidence but less than proof beyond a reasonable doubt (11 of 13). Others suggested that, in practice, the important question in AOT cases is whether the respondent would benefit from the AOT program and whether the treatment plan makes sense. Judge 9: “It’s mostly evidence that shows this person has a problem and would benefit from AOT.” Judge 11: “I listen to what they have to say and I go with what makes the most sense.” Judge 3: “I do what I think is right.” Judge 2: “Judges will do what they feel is the right thing.”

c. Attorney Role: Zealous Advocacy or Best Interests?

Attorneys consistently expressed a strong professional obligation to advocate zealously for AOT clients, just as they would in any other legal proceeding. By contrast judges were less consistent in their perceptions of the defense attorney’s role. A small number of judges (3 of 13) felt that attorneys do a disservice to their clients when they object to hearsay or argue too zealously on their behalf, without considering the consequences. As one judge said: “knowing that this person may have an illness and may need certain things, it’s better not to be totally zealous in your position but be reasonable and try to test whether or not AOT is necessary for this person” (Judge 2). He continued: “Try to impress upon the judge why this or that should or shouldn’t be, but again, not to

¹³¹ *Ausch v. St Paul & Marine Ins. Co.*, 511 N.Y.S.2d. 919, 912-22 (2d Dep’t 1987) (approving jury instruction that used “highly probable” language to describe clear and convincing evidence); *Chenango Mut. Ins. Co. v. Charles*, 652 N.Y.S. 2d 134 (3d Dep’t 1997)(clear and convincing evidence standard requires “high probability”).

the extent that you know, a win at all costs. That could happen and that's a pyrrhic victory. You let somebody out and they need services and they're going to be back in the hospital" (Judge 2).

V. DISCUSSION

This study explored four elements of procedural due process under Kendra's Law—the right to a hearing, the right to counsel, the standard of proof and the right to a neutral factfinder. Findings from this study suggest that AOT hearings adhere to the fundamental requirements of procedural due process. Contested AOT hearings were approximately 20 minutes on average, affording respondents a meaningful opportunity to be heard. In contrast to earlier studies on inpatient civil commitment, attorneys usually attacked the most important aspects of the petitioner's testimony. For example, attorneys frequently challenged the petitioner's assertion that their clients were unlikely to participate in outpatient treatment voluntarily. In almost half of the contested cases observed, attorneys challenged the petitioner's claim that their clients were unlikely to survive safely in the community or needed AOT to prevent harm to others.

Defense attorneys also underscored their professional obligations to represent their clients zealously and to the full extent of the law. Prior studies on the assisted outpatient program have reported broad upstate-downstate differences in perceptions of attorney role among attorneys in the AOT program. Others have argued that even within the New York City region, MHLS attorneys in the First and Second Judicial Department have very different views of client advocacy. In contrast to these authors, this study found no noticeable differences in perceptions of attorney role across boroughs or between judicial departments.

This study also aimed to understand how judges define the term "clear and convincing evidence" and what constitutes clear and convincing evidence that someone meets the criteria for AOT as required by law. In a large majority of cases an AOT Team psychiatrist testified that the

respondent was unlikely to comply with outpatient treatment voluntarily because the respondent failed to attend one or more days of a court ordered outpatient treatment program. In almost half of the contested cases observed a psychiatrist testified that the respondent lacked insight into his or her illness; or without a court order, the respondent would discontinue medications, and in doing so, present a risk of harm to self or others. In *Addington v. Texas*, the Supreme Court conceded that the difference between a preponderance of the evidence and proof beyond a reasonable doubt is probably better understood than the meaning of clear and convincing evidence.¹³² In the same way, judges often defined “clear and convincing evidence” broadly, as something between a preponderance and proof beyond a reasonable doubt, while a sizeable number conceded that in practice, the important question is whether outpatient commitment is in the respondent’s “best interests” or otherwise makes sense.

In lengthy and surprisingly candid interviews, many judges reported that they rely heavily on clinical recommendations particularly when the clinician has appeared before them in prior hearings and established a reputation for credibility. What do these findings imply for the respondent’s right to be heard by a neutral factfinder? Scholars who observed civil commitment hearings in the 1960s and 70s frequently described the proceedings as “a legal charade” in which judges rubber stamped medical recommendations and abdicated their role as neutral factfinders to clinicians.¹³³ Yet, at least since *Parham*, the Supreme Court has expressed a decided preference for medical rather than judicial decision-making in cases concerning the involuntary treatment of people with mental illnesses.¹³⁴

¹³² See *infra* notes 49-51 and accompanying text.

¹³³ See *infra* note 76 and accompanying text.

¹³⁴ See *Parham v. J.R.* 442 U.S. 584, 608 (1977) (“[t]he mode and procedure of medical diagnostic procedures is not the business of judges.”); See also *Washington v. Harper* 494 U.S. 210, 211-212 (1990) (while mentally ill inmates have a liberty interest in avoiding unwanted psychiatric medications, “an inmate’s interests are adequately protected, and perhaps better served, by allowing the decision to medicate to be made by a medical professionals rather than a judge.”).

Heavy reliance on credible recommendations may be troubling in some respects, but it is certainly consistent with the respondent's right to a neutral factfinder under the Fourteenth Amendment.

Policymakers should consider educating judges on the strengths and weaknesses of clinical testimony. For example we know that mental health professionals tend to overestimate the risk of violence.¹³⁵ The Office of Mental Health should encourage psychiatrists to use actuarial methods based on a standardized list of validated risk factors, such as age, gender and past history of violence, rather than unstructured judgments based on clinical experience. Most studies have shown that actuarial methods tend to be more accurate than clinical predictions.¹³⁶

A small but substantial number of judges also stated that testimony from respondents regarding their plans to continue taking medication without a court order has little, if any, impact on their rulings. Others felt that without expert testimony they had no "basis" to rule in favor of a person who is objecting to AOT. Michael Perlin has written extensively on the corrosive effects of "sanism" and "pretextuality" in mental health law.¹³⁷ As Perlin writes, "sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry."¹³⁸ Sanism is based on myths and stereotypes regarding people with mental illnesses and it is sustained by our reliance

¹³⁵ See, e.g., Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 J. AM. MED. ASS'N 1007 (1993).

¹³⁶ See, e.g., William Gardner, Charles Lidz et al., *Clinical Versus Actuarial Predictions of Violence in Patients with Mental Illnesses*, 64 J. Consulting & Clinical Psychol. 602 (1996); See also William M. Grove & Paul Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y & L. 293 (1996).

¹³⁷ See generally Michael L. Perlin, *Morality and Pretextuality, Psychiatry and Law: Of "Ordinary Common Sense," Heuristic Reasoning, and Cognitive Dissonance*, 19 BULL. AM. ACAD. PSYCHIATRY & L. 131 (1991); Michael L. Perlin, *On "Sanism,"* 46 S.M.U.L. Rev. 373, 374 (1992).

¹³⁸ Michael L. Perlin, *"Half-Wrecked Prejudice Leaped Forth" Sanism, Pretextuality, and Why and How Mental Disability Law Developed as It Did*, J. CONTEMP. LEGAL ISSUES 4 (1999).

on heuristic reasoning, or simply put, alleged “ordinary commonsense.”¹³⁹ What’s more the pretext of careful consideration “breeds cynicism and disrespect for the law,” “demeans participants,” and promotes “blasé judging.”¹⁴⁰

To some extent Perlin is right. Very few judges explained their rulings. In some courtrooms judges simply restated the criteria for issuing an AOT order and inserted the petitioner’s facts for the record, without addressing any of the respondent’s arguments. In most courtrooms judges declined to render their judgments in front of AOT recipients for fear that doing so would provoke an outburst or worse. Judges frequently stated, and perhaps overstated, the possibility that without a court order AOT recipients, might present a substantial risk of harm to others. The tendency to refer to the violent origins of Kendra’s Law as a justification for issuing an AOT order raises an important question about how legislatures frame mental health laws and how those framing effects influence judicial decision-making. On the other hand, to interpret these findings as evidence of unmitigated sanism would be a mistake. The central question in most AOT hearings is whether the respondent will continue to participate in outpatient treatment voluntarily, without a court order. AOT recipients who testify that they will continue taking their medications without a court order, when their most recent history is one of noncompliance, usually lack credibility.

Of the 185 hearings observed by the author, 49 were contested and courts granted the petitioner’s request for assisted outpatient treatment in 48 of the 49 contested cases observed. Given the high rate at which AOT petitions were granted, findings from this study suggest that an important direction for future research is to understand how clinicians decide whether to petition courts for assisted outpatient treatment. What distinguishes patients who are the subject of petitions

¹³⁹ *Id.* at 14.

¹⁴⁰ *Id.* at 4.

for AOT from those who are not? What factors are most important to their decisions? According to the New York State Office of Mental Health, 7,657 petitions for assisted outpatient treatment have been filed since the program began in November 1999. Of them, 7,463 petitions have been granted (97 percent) and only 194 petitions have been denied (3 percent).¹⁴¹

In this study 49 petitions for assisted outpatient treatment were contested, 48 were granted (98 percent) and only 1 petition was denied (2 percent). How different was that case from all the others? The psychiatrist testified that in his opinion the respondent's prognosis without AOT would be poor since he denied having a mental illness and stated that he only takes medications "because he has to." Moreover the respondent failed to take his medications consistently during the AOT order. The respondent testified that he was misunderstood. He would take his medications and his family would make sure that he takes his medications, therefore he didn't need AOT. What made the difference? Members of the respondent's family appeared in court to testify on his behalf, however that was not unusual. On the other hand, the case was decided by a judge who is known for occasionally denying AOT petitions. Three-quarters of AOT recipients have a diagnosis of schizophrenia, although the respondent in this case had been diagnosed with bipolar disorder, a far less stigmatized mental disorder. Further research is need to understand what distinguishes the vast majority of cases in which AOT petitions are granted from those that are not, and whether those factors are germane to the criteria for issuing an AOT order.

The methods used in this study were subject to limitations. The rate at which AOT hearings are contested in each borough is unknown; therefore, the number of contested hearings observed in each borough may not reflect the actual distribution contested AOT hearings in New York City. Second, in contrast to other research in this area, only one observer recorded data on AOT hearings.

¹⁴¹ NEW YORK STATE OFFICE OF MENTAL HEALTH, ASSISTED OUTPATIENT TREATMENT REPORTS, <http://bi.omh.state.ny.us/aot/statistics> (last visited April 23, 2013).

Third, hearing observations were limited to testimony and did not include a review of AOT petitions, due to legal restrictions on access to court records. Fourth, responses to questions regarding the professional obligations of attorneys and how AOT hearings are decided may reflect a response bias toward socially desirable attitudes. Data collection for this study was also limited to the five boroughs of New York City and therefore, findings from this study may not be generalizable to other areas of New York State. Finally, conclusions regarding clear and convincing evidence in this study rest on the assumption that AOT attorneys present evidence on matters of importance to the factfinder. Nothing in this study should be interpreted to suggest that evidence in these categories is necessary to establish clear and convincing, or that this evidence *ought* to establish clear and convincing evidence.

Even so, this study provides a valuable contribution to our understanding of Kendra's Law. Most AOT decisions are not published, therefore, we know very little about how AOT cases are decided. Findings from this study also suggest room for improvement, for example—encouraging judges to explain their rulings so that AOT recipients understand why they are under a court order and how future orders can be avoided. Legislators should also consider funding for expert witnesses to be employed by the Mental Hygiene Legal Service, rather than the Office of Court Administration. Even if *Dolan v. K-W* was correctly decided and respondents in AOT proceedings are not entitled to an expert witness as a matter of law, in order to reach an accurate decision, courts need to hear a more complete set of facts than the statute currently requires.

CHAPTER 2

RETHINKING KENDRA'S LAW: THE ETHICS OF ASSISTED OUTPATIENT TREATMENT

In the wake of deinstitutionalization and its failures, one of the most important questions in mental health policy may be this: how can we care for psychiatric patients in the community who require care, but resist treatment nonetheless? Left to their own devices, so called “revolving door patients” will stop taking their medications and decompensate in the community, cycling between hospitals, jails and homelessness. Eventually, revolving door patients will deteriorate in the community and meet the criteria for inpatient civil commitment—clear and convincing evidence of both mental illness and dangerousness to self or others. However, preventive outpatient commitment has emerged as a tool to authorize court ordered community treatment for people who do not yet meet the criteria for inpatient commitment, but who are expected to deteriorate substantially in the future.

In 1999 New York enacted Kendra's Law, in memory of Kendra Webdale, a young woman who was pushed to her death in front of an oncoming train by Andrew Goldstein, a man with untreated schizophrenia. Under Kendra's Law, a court can order a person with a mental illness to participate in an “assisted outpatient treatment” (AOT) program. A typical AOT order will include a host of interventions designed to improve medication compliance in the community, among them—periodic blood tests or urinalysis to determine compliance with prescribed medications; counseling and toxicology screens for patients with a history of substance abuse; group therapy for several hours a day, several days a week; day or partial day programming; and supervised living arrangements.¹⁴² For those who are not under a supervised housing requirement, courts will sometimes order an “ACT” or assertive community treatment team to visit the patient's home.

¹⁴² N.Y. MENTAL HYG. LAW § 9.60 (a)(1)(2006).

Recent empirical work suggests that participation in the AOT program is associated with significant benefits for people with mental illnesses. A 2009 study found that when compared to their counterparts in voluntary treatment, participants in the assisted outpatient treatment program were more likely to receive appropriate medications, less likely to be hospitalized, and less likely to be arrested.¹⁴³ Although the effectiveness of outpatient commitment remains a matter of some controversy, this paper will assume that under the right circumstances AOT can lead to significant reductions in the revolving door problem.¹⁴⁴

However effective, court-ordered participation in outpatient treatment remains something of an anomaly in public health. Proponents of Kendra's Law will rest the justification for outpatient commitment on the harm that untreated mental illness poses to oneself and others. Yet by itself, harm fails to provide a principled distinction between people with mental illnesses and others who might also refuse treatment. Consider the alcoholic who persists in driving drunk. We could easily imagine a Kendra's Law for people with substance abuse disorders—replete with weekly AA meetings, toxicology tests and home visits where ACT teams conduct “bottle checks” instead of pill checks. Such a regime would pay dividends in preventable death, and yet we don't have one. Even the most outspoken supporter of Kendra's Law must concede that the risk posed by untreated

¹⁴³ Martin S. Swartz, Henry J. Steadman, & John Monahan, NEW YORK STATE ASSISTED OUTPATIENT TREATMENT PROGRAM EVALUATION, http://www.omh.ny.gov/omhweb/resources/publications/aot_program_evaluation/ (last visited Sept. 2, 2012).

¹⁴⁴ See Virginia Aldigé Hiday, *Outpatient Commitment: The State of Empirical Research on Its Outcomes*, 92 PSYCHOL. PUB. POL'Y & L. 8 (2003) (for an overview of empirical studies on outpatient commitment); see also Marvin S. Swartz et al., *Can Involuntary Outpatient Commitment Reduce Hospital Recidivism?* 156 AM. J. PSYCHIATRY 1968, 1973 (1999) (finding that study subjects who underwent sustained periods of outpatient commitment for 6 months or more had 57% fewer readmissions or 20 fewer hospital days when compared to control subjects. Among study participants with schizophrenia, schizoaffective disorder, or another form of psychosis, sustained outpatient commitment was associated with a 72% reduction in hospital admissions or 28 fewer hospital days); see also Jeffrey W. Swanson et al., *Involuntary Out-Patient Commitment and Reduction of Violent Behaviour in Persons With Severe Mental Illness*, 176 BRIT. J. PSYCHIATRY 224, 228-29 (2000) (finding a lower incidence of violence among study subjects who were required to participate in 6 months of outpatient commitment or more); But see Henry J. Steadman et al., *Assessing the New York City Involuntary Outpatient Commitment Pilot Program*, PSYCHIATRIC SERVICES (2001) (finding no statistically significant differences between the control and experimental group on all major outcomes).

mental illness is distinguishable from tuberculosis and other forms of communicable disease for which there is an established precedent for preventive intervention. In that sense, Kendra's Law raises a longstanding question in law, ethics and public health—what's so special about mental illness?¹⁴⁵

Resting the argument for assisted outpatient treatment on harm to self seems equally problematic. We do not require people with diabetes to take medications that have the power to prevent blindness, amputation, coma and death. Nor do we require smokers to stop smoking any more than we require people with cardiovascular disease or high cholesterol to participate in classes on the dangers of inactivity and a fatty diet. As a general matter, courts do not intervene in self-regarding treatment decisions, without a finding of incompetence, no matter how grave the potential harm. One might think that court ordered participation in an AOT program under Kendra's Law is justified by virtue of the fact that unlike people with general medical conditions, people with mental illnesses lack the capacity to make treatment decisions on their own. Absent capacity, courts may step in and order treatment for them. However, not all people with mental illnesses are unable to make competent treatment decisions and Kendra's Law does not require a judicial finding of incompetence.¹⁴⁶ Indeed in upholding Kendra's Law against constitutional attack, the New York State Court of Appeals noted that Kendra's Law expressly contemplates the possibility that patients will have the capacity to participate in decisions regarding their treatment plan.¹⁴⁷

¹⁴⁵ See e.g. JOEL FEINBERG, *What's So Special About Mental Illness?* in *DOING & DESERVING: ESSAYS IN THE THEORY OF RESPONSIBILITY*, 272 (1974) (for a classic discussion); see also ELLEN SAKS, *FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL* 44-84 (2002).

¹⁴⁶ See e.g. Paul S. Appelbaum & Thomas Grisso, *MacArthur Treatment Competence Study: Mental Illness and Competence to Consent to Treatment*, 19 L. & HUM BEHAV. 105 (1995) (finding that most people who have been hospitalized for serious mental illness have similar abilities to make treatment decisions, when compared to people without a major mental illness).

¹⁴⁷ In re K.L., 774 N.Y.S.2d 472, 476 (N.Y. App. Div. 2004).

Instead, supporters of Kendra's Law will argue that quite unlike people with diabetes, cardiovascular disease and high cholesterol, many people with major mental illnesses like schizophrenia, bipolar disorder and depression lack insight into their illnesses, and when combined with a substantial risk of harm to self or others, this lack of insight provides sufficient justification for court ordered treatment. However, this paper will recommend that we reject an impaired insight standard, and only order participation in outpatient treatment for those who are unable to make competent treatment decisions on their own.

Part I provides a brief history of deinstitutionalization and its pitfalls. Part II provides an overview of Kendra's Law. Part III examines justifications for assisted outpatient treatment based on the harm that untreated mental illness presents to others, while Part IV considers justifications for AOT based on harm to oneself. Part V will pay close attention to impaired insight as a principled distinction between people with mental illnesses and others. Although Kendra's Law was enacted in response to an act of violence, more often than not, our primary concern will be that without outpatient treatment, most candidates for assisted outpatient treatment will stop taking their medications, and in the absence of family or other social supports, many will find it difficult to meet their needs for food, clothing and shelter. When our primary concern is one of self-regarding harm, Part V contends that a court order to participate in outpatient treatment may be appropriate, but only for people with mental illnesses who are unable to make competent treatment decisions on their own. At times, we will also worry that a decision to refuse outpatient treatment could not only result in harm to oneself, but harm to others. When our primary concern is one of other-regarding harm, Part VI contends that courts should limit assisted outpatient treatment to people with mental illnesses who are unlikely to appreciate the wrongfulness of their conduct or those who lack the capacity to conform their conduct to the requirements of the law.

I. DEINSTITUTIONALIZATION: PITFALLS AND PROMISES

By the mid-1950s, when the number of institutionalized psychiatric patients reached its peak, more than 550,000 inpatients resided in state mental hospitals.¹⁴⁸ By the mid-1980s, however, fewer than 120,000 psychiatric patients resided in state hospitals.¹⁴⁹ Several factors encouraged a shift toward community-based care. By the late 1950s, attitudes toward institutional psychiatry began to change.¹⁵⁰ Labeling theorists and small group of radical anti-psychiatrists insisted that psychiatric diagnoses were no more than convenient labels designed to suppress nonconforming behavior.¹⁵¹ So labeled, persons deemed mentally ill would in turn reproduce more disturbed behavior. A second critique of psychiatry concerned the benefits of long-term hospitalization. In the years following World War II, a series of exposés called attention to deplorable conditions in state hospitals.¹⁵² For the first time, the emergence of psychotropic medications also offered the possibility of treating people with mental illnesses in the community.¹⁵³

A further critique of psychiatry came from the civil rights movement. After an initial focus on racial inequality, the postwar civil rights movement gradually expanded to include a concern for the rights of women, the poor and eventually, the civil liberties of people with mental illnesses.¹⁵⁴

¹⁴⁸ DEINSTITUTIONALIZATION: PROBLEMS AND PROMISE 5 (Richard H. Lamb & Linda Weinberger eds., 2001).

¹⁴⁹ GERALD N. GROB, *THE MAD AMONG US: THE HISTORY OF THE CARE OF AMERICA'S MENTALLY ILL*, 291(1994).

¹⁵⁰ PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 4 (1994).

¹⁵¹ *Id.* at 4-7.

¹⁵² *Id.* at 8.

¹⁵³ *Id.*

¹⁵⁴ *See* GROB, *supra* note 149 at 274.

Civil rights organizations argued that inpatient commitment standards were vague, overbroad and void for failure to consider less restrictive alternatives to involuntary hospitalization.¹⁵⁵ State hospital closures also accelerated rapidly in the late 1960s with introduction of Medicare and Medicaid. When Congress passed Medicaid in 1965, the federal government excluded Medicaid payments for psychiatric services rendered in state hospitals. In response, states discharged large numbers of former inpatients to nursing homes and other congregate care arrangements where Medicaid reimbursement was available.¹⁵⁶

While some former inpatients did well in the community, many others did not. Far fewer community mental health centers were created than anticipated, making it difficult for former inpatients to access care.¹⁵⁷ Some former patients refused treatment owing to the symptoms of their mental illness, while others refused treatment owing to the side effects of their medications and a longstanding distrust of the mental health system.¹⁵⁸ Yet, even when the need for treatment was clear, by the late 1970s, in most states involuntary hospitalization required clear and convincing evidence of dangerousness to self or others.¹⁵⁹ With the introduction of managed care, the combination of shorter hospital stays and stricter commitment laws fostered a revolving door syndrome. Patients were routinely stabilized in hospitals and released, only to stop taking their medications, decompensate in the community and once again require rehospitalization.

¹⁵⁵ *Lessard v Schmidt*, 349 F.Supp. 1078, 1093 (E.D. Wis. 1972).

¹⁵⁶ GROB *supra* note 154, at 289-91; *see also* APPELBAUM, *supra* note 150, at 50-1.

¹⁵⁷ GROB *supra* note 154, at 283-87.

¹⁵⁸ Howard Telson et al., REPORT OF THE BELLEVUE HOSPITAL CENTER OUTPATIENT COMMITMENT PILOT PROGRAM. Department of Psychiatry, Bellevue Hospital, New York (1999).

¹⁵⁹ APPELBAUM *supra* note 150, at 27-8.

In New York, “Billie Boggs” and Larry Hogue came to symbolize the failures of the public mental health system. Boggs first appeared on the streets of Manhattan in 1987.¹⁶⁰ For almost a year, Billie Boggs lived on the corner of Second Avenue and 65th Street, urinating and defecating on the sidewalk, burning dollar bills, and screaming obscenities when assistance was offered.¹⁶¹ In October 1987, Boggs was picked up by a local program designed to remove people with mental illnesses from the streets when their lives were threatened by severe weather and hypothermia.¹⁶² When the program attempted to hospitalize her, Boggs sued and won her freedom with the help of the New York Civil Liberties Union.¹⁶³ According to a psychiatrist, although Boggs suffered from paranoid schizophrenia, she understood the risks and benefits of treatment; therefore, the hospital could not medicate her against her will.¹⁶⁴ As a result, the hospital agreed to her release. After her discharge, Boggs enjoyed a brief stint as a national celebrity. She appeared on “60 minutes” and “Donahue,” and in February 1988, she appeared as a guest speaker at Harvard Law School.¹⁶⁵ Yet, only a few weeks later, the symptoms of her psychosis reappeared and Boggs was once again panhandling on the streets of Manhattan.¹⁶⁶

¹⁶⁰ GERALD N. GROB, *THE MAD AMONG US: THE HISTORY OF THE CARE OF AMERICA’S MENTALLY ILL*, 302 (1994).

¹⁶¹ Jeanie Kasindorf, *The Real Story of Billie Boggs: Was Koch Right or the Civil Libertarians?* N.Y. MAG., May 2, 1988, at 36.

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ GROB *supra* note 154, at 303.

¹⁶⁵ Kasindorf, *supra* note 161, at 44.

¹⁶⁶ Rick Hampson, *After a Brief Encounter with Fame, Homeless Billie Boggs Fades Away*. THE FREE LANCE STAR, Jun 3, 1991, at 9.

Several years later, Larry Hogue gained notoriety among New Yorkers as “the Wild Man of 96th Street.”¹⁶⁷ For years, Hogue terrorized New Yorkers on Manhattan’s Upper West Side by siphoning gasoline from parked cars, igniting newspapers soaked with gas and then stuffing them into tailpipes.¹⁶⁸ Over the years, witnesses also observed Hogue jumping into oncoming traffic and threatening people on the street with a nail-studded club.¹⁶⁹ In 1989, Hogue was convicted of reckless endangerment for pushing a teenage girl in front of an oncoming truck.¹⁷⁰ Yet because these incidents never resulted in serious injury, Hogue never spent more than a year in jail.¹⁷¹ As a patient at Creedmoor Hospital, Hogue was diagnosed with bipolar disorder, crack addiction and a traumatic brain injury.¹⁷² According to his doctors, when Hogue was hospitalized and no longer abusing drugs, he was calm and amiable. Yet, inevitably following his release, Hogue would stop taking his medications and revert to using drugs, leading him to behave in ways that once again rendered him a danger to himself and others.¹⁷³

By the early 1990s, the idea for an outpatient commitment law was already well underway in the New York State Legislature. In 1994, the Legislature established a pilot outpatient commitment

¹⁶⁷ Leigh Remizowski et al., *The Wild Man of 96th St., Larry Hogue, Caught by Police on Upper West Side*, N.Y. DAILY NEWS, May 30, 2009, http://articles.nydailynews.com/2009-05-30/local/17922790_1_96th-larry-hogue-drug-habit.

¹⁶⁸ *Seltzer v. Hogue*, 594 N.Y.S.2d 781, 782 (N.Y. 1993.)

¹⁶⁹ Remizowski, *supra* note 166.

¹⁷⁰ Richard Perez-Pena, *Crack Addict Found Able to Face Trial*, N.Y. TIMES, Dec. 8, 1992, at B3.

¹⁷¹ *Id.*

¹⁷² *Hogue*, 594 N.Y.S.2d at 783.

¹⁷³ GROB *supra* note 154, at 304.

program at Bellevue Hospital in lower Manhattan.¹⁷⁴ In a twist of fate, Andrew Goldstein visited the psychiatric emergency room of Bellevue Hospital on at least two occasions in 1998, during the tenure of the pilot program, complaining of auditory hallucinations and sleep deprivation.¹⁷⁵ After a few days in the hospital, Goldstein was released.¹⁷⁶ A subsequent investigation into the quality of care Andrew Goldstein received found that Goldstein repeatedly sought help for hallucinations and delusions.¹⁷⁷ In the two year period between early 1997 and January 1999, Goldstein voluntarily admitted himself to state hospitals no less than 13 times.¹⁷⁸ On more than one occasion, Goldstein requested long-term hospitalization at Creedmoor.¹⁷⁹ More often than not, he was turned down. Under tremendous pressure to cut costs and reduce the number of inpatients, the hospital could do little more than place Goldstein on a waiting list.

Several months later, in January 1999, Andrew Goldstein pushed Kendra Webdale in front of an oncoming subway train. In Albany, former Attorney General Elliot Spitzer seized the opportunity to create a permanent outpatient commitment program in New York. In a statement to the press, Spitzer alluded to the problems associated with deinstitutionalization:

¹⁷⁴ N.Y. MENTAL HYG. LAW § 41.55 (1993).

¹⁷⁵ Michael Winerip, *Bedlam on the Streets*, N.Y. TIMES, May 23, 1999, at A6.

¹⁷⁶ *Id.*

¹⁷⁷ NEW YORK STATE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED, IN THE MATTER OF DAVID DIX : A REPORT BY THE NEW YORK STATE COMMISSION ON QUALITY OF CARE FOR THE MENTALLY DISABLED AND THE MENTAL HYGIENE MEDICAL REVIEW BOARD (1999).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

It is clear that the law must be changed to protect both the public and the mentally ill from danger....The movement to deinstitutionalize has proven to be a double-edged sword. Most individuals can and do function well in society, but others with severe mental illness who are not taking their prescribed medication can be a serious threat to themselves and the public.¹⁸⁰

Three months later Julio Perez, a homeless man suffering from paranoid schizophrenia, pushed Edgar Rivera into the path of an oncoming train, severing both of his legs.¹⁸¹ According to his attorney, Perez harbored a delusional belief that a conspiratorial network of Mexican assassins was trying to kill him. Perez pushed Rivera, believing Rivera to be part of that network.¹⁸²

In December 2012, after years of intermittent contact with mental health and law enforcement, Erika Mendez pushed Sunando Sen onto the tracks of a subway station in Queens.¹⁸³ In a tragic incident that shocked the world, Adam Lanza, a 20 year-old man believed to have Asperger's Syndrome, shot and killed 26 elementary schoolchildren and their teachers in Newtown, Connecticut.¹⁸⁴ In New York, public outrage, following the shooting in Newtown—as well as the death of Sunando Sen—has lead a renewed interest in compulsory treatment.¹⁸⁵

¹⁸⁰ Press Release, Spitzer Proposes Mental Illness Legislation (Jan. 28, 1999) *available at* <http://www.ag.ny.gov/press-release/spitzer-proposes-mental-illness-legislation> (last visited Oct. 1, 2012); *see also* Press Release, *Speaker Silver Joins Attorney General Spitzer in Calling for Passage of Kendra's Law*, *available at* <http://www.ag.ny.gov/press-release/speaker-silver-joins-attorney-general-spitzer-calling-passage-kendras-law> (last visited Oct. 1, 2012); Eliot Spitzer, *Is Kendra's Law The Answer? Yes*, 221 N.Y. L. J. 1 (1999).

¹⁸¹ Andrew Jacobs, *Man Is Pushed in The Subway and Loses Legs*, N.Y. TIMES, April 29, 1999, at A1.

¹⁸² Associated Press, *Jury Finds Subway Pusher Guilty of Attempted Murder*, N.Y. TIMES, October, 22, 2000, at A1.

¹⁸³ Marc Santora & Anemona Hartocollis, *Troubled Past for Suspect in Fatal Subway Push*, N.Y. TIMES, December 31, 2012, at A.

¹⁸⁴ David M. Halbfinger, *A Gunman, Recalled as Intelligent and Shy, Who Left Few Footprints in Life*, N.Y. TIMES, December 14, 2012, at A18.

¹⁸⁵ *See* note 55 *infra* (in addition to strengthening state gun control laws, the 2013 NY Secure Ammunition and Firearms Enforcement Act, SAFE, strengthens and extends Kendra's Law); *See also* Sophia Hollander & Joseph De Avila, *'Holes' Are Seen in Kendra's Law*, *available at* <http://online.wsj.com>. (last visited Jan. 30 2013).

II. KENDRA'S LAW

In addition to Kendra's Law, thirty-six states and the District of Columbia have outpatient commitment laws.¹⁸⁶ Kendra's Law is only one of at least three types of outpatient commitment. The first, conditional release, applies to patients who have been hospitalized and released on the condition that they comply with a treatment plan in the community. Outpatient commitment might also be used as a less restrictive alternative to hospitalization for patients who meet the criteria for inpatient commitment, but who can be treated safely in the community nonetheless. A third, and far more controversial form of commitment, preventive outpatient commitment, applies to individuals who do not yet meet the criteria for inpatient commitment, but who are expected to deteriorate substantially in the future.

Kendra's Law authorizes preventive outpatient commitment for people with mental illnesses who do not meet the criteria for inpatient civil commitment in New York. Under Kendra's Law a court may order a person who is 18 or older to comply with an assisted outpatient treatment plan if the court finds by clear and convincing evidence that the subject of the treatment plan meets the following criteria. He or she must be suffering from a mental illness and "unlikely to survive safely in the community without supervision, based on a clinical determination."¹⁸⁷ The court must also

¹⁸⁶ See ALA.CODE § 22-52-10.2 (1991); ARIZ. REV. STAT. ANN. §36-540(2011); ARK. CODE. ANN. §20-47-214(b)(1)(2007); COLO. REV. STAT. ANN. §27-65-111 (2010); DEL CODE. ANN. 16 §5010(2) (2011); D.C. CODE §21-545(b)(2012); GA. CODE ANN. §37-3-81.1(2)(1991); HAW. REV. STAT. §334-121(1992); IDAHO CODE ANN. 66-339A (1998); 405 ILL. COMP. STAT. §5/3-751(2011); IND. CODE §12-26-14-1(1993); IOWA CODE ANN. §229.13(2004); KAN. STAT. ANN. §59-2967(2010); KY. REV. STAT. ANN. §202A.081(1)(1994); LA. REV. STAT. ANN. §28:55(E)(1)(2012); MICH. COMP. LAWS §330.1468 (1996); MINN. STAT. §253B.065(5)(b)(2007); MISS CODE. ANN. §41-21-73(4)(2010); MO. REV. STAT. §632.330(2)(1996); MONT. CODE ANN. §53-21-127(2)(1996); NEB. REV. STAT. §71-909(2004); NY. MENTAL HYG. §9.60(c)(2010); N.C. GEN. STAT. § 122C-263(d)(1)(2009); N.D. CENT. CODE §25-03.1-20(1)(1977); OHIO REV. CODE ANN. § 5122.15(C) (2011); 43(A) OKLA. STAT § 5-415(E) (2010); OR. REV. STAT. § 426.130(1)(b)(C)(ii)(2009); 50 PA. STAT. ANN. §7304 (1976); R.I. GEN LAWS § 40.1-5-8(j)(1993); S.C. CODE ANN 1976 §44-17-580(2005); S.D. LAWS 27A-9-10.1 (2000); TEX. HEALTH & SAFETY CODE ANN. §574.034(b)(1997); UTAH CODE ANN. 1953 §62A-12-234(10)(2012); VA. CODE ANN. §37.1-67.3(2009); WASH. REV. CODE §71.05.240 (2009); W. VA. CODE §27-1-9 (2010); WYO. STAT. ANN.1977 §25-10-110(j)(2010).

¹⁸⁷ N.Y. MENTAL HYG. LAW § 9.60 (c)(2) – (3) (2006).

find that a history of treatment noncompliance has either: (i) been a significant factor leading to hospitalization at least twice within the last thirty-six months, or (ii) resulted in one or more acts of violent behavior toward self or others within the last forty-eight months, or at least a threat or attempt at serious physical harm to self or others within the last forty-eight months.¹⁸⁸ In addition, the petitioner must provide clear and convincing evidence that the subject of the petition is unlikely to participate in outpatient treatment voluntarily “as a result of his or her mental illness.”¹⁸⁹ Assisted outpatient treatment must be necessary to prevent a relapse or deterioration, “which would be likely to result in serious harm to the person or others.”¹⁹⁰ Finally, the person must be likely to benefit from treatment, and assisted outpatient treatment must be the least restrictive form of treatment available.¹⁹¹

In New York, involuntary hospitalization requires a finding that the subject of a petition for inpatient commitment presents “a substantial risk of physical harm” to self or others.¹⁹² By contrast, Kendra’s Law permits outpatient commitment, largely on the ground that treatment noncompliance has lead to multiple hospitalizations and without outpatient commitment, the person is likely to decompensate, becoming a danger to himself or others. The result is that the subject of an AOT petition can be ordered to comply with treatment, even though at present, he or she does not present a substantial risk of physical harm to self or others. If the subject of the petition meets the

¹⁸⁸ *Id.* § 9.60 (c)(2)(4)(i) – (ii) (2006).

¹⁸⁹ *Id.* § 9.60 (c)(5)(2006).

¹⁹⁰ *Id.* § 9.60 (c)(5) – (6) (2006).

¹⁹¹ *Id.* § 9.60 (c)(7) (2006); § 9.60 (h)(3) (2006).

¹⁹² N.Y. MENTAL HYG. LAW § 9.37(a)(1-2) (2006).

criteria for AOT, the court may order assisted outpatient treatment for up to six months.¹⁹³ Thirty days prior to the expiration of an AOT order, the petitioner may seek continued assisted outpatient treatment for up to one year.¹⁹⁴

Under Kendra's Law, a court may order a person to self-administer psychotropic drugs, or accept the administration of such drugs by authorized personnel.¹⁹⁵ However, like most outpatient commitment statutes, Kendra's Law does not authorize forced administration of medication over the patient's objection. If a patient refuses to comply with any aspect of the AOT order, and a physician determines that the patient may be in need of involuntary hospitalization, patients may be removed from the community and detained in a hospital where they can be held for up to 72 hours to determine whether they meet the criteria for inpatient civil commitment.¹⁹⁶

III. HARM TO OTHERS

What moral justifications can we offer for outpatient commitment? Ken Kress, a strong supporter of outpatient commitment has argued that in many cases of actual or threatened violence by a person with a mental illness, the perpetrator was either not being treated for his or her mental

¹⁹³ N.Y. MENTAL HYG. LAW § 9.60 (k)(2006).

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* §9.60(h)(i) (2006).

¹⁹⁶ N.Y. MENTAL HYG. LAW § 9.60 (o)(2006); *See also* NY Secure Ammunition and Firearms Enforcement (SAFE) ACT, 2013 N.Y. Laws 1. (In addition to strengthening state gun control laws, the SAFE Act: (i) extends Kendra's Law for two years from its original sunset date of June 30, 2015 to June 30, 2017; (ii) extends the maximum duration of an initial AOT order from 6 months to 1 year; (iii) mandates a review by the local director of community services within 30 days prior to the expiration of an AOT order; (iv) authorizes AOT treatment order across county lines; and (v) requires a clinical assessment for an inmate committed to a state correctional facility from a psychiatric hospital prior to discharge).

disorder, or not taking prescribed medications.¹⁹⁷ Moreover, most of these incidents, many of them homicides, could have been prevented if there were laws in place to insist that people with mental illnesses participate in treatment whether they want to or not.¹⁹⁸

What should we make of these claims? Part III will review empirical studies on the relationship between mental illness and violence. Although support for outpatient commitment stems from high profile acts of violence committed by people with mental illnesses, most violent crimes are not committed by people with mental illnesses, and most people with mental illnesses are no more violent than anyone else. A second argument concedes that most people with mental illnesses are no more dangerous than members of the general population, but insists that a subgroup of people with mental illnesses *are* more dangerous.¹⁹⁹ To that end, Kendra's Law is necessary to prevent tragedies, like the Webdale incident, from happening again.²⁰⁰ Call this the preventable tragedies argument.

As the remainder of Part III asserts, the problem with this argument is twofold. First, using Kendra's Law to prevent tragedies, such as the Webdale incident, from happening again presumes that we have a reasonably reliable way to identify people with mental illnesses who are likely to be violent and distinguish them from those who are not. However, clinical predictions of violence are only slightly better than chance. Second, even if we were able to identify people with mental illnesses who are likely to be violent, we can identify statistically significant associations between

¹⁹⁷ Ken Kress, *An Argument for Assisted Outpatient Treatment for People with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1283 (2000).

¹⁹⁸ *Id.*

¹⁹⁹ See e.g. E. Fuller Torrey, *Violent Behavior by Individuals with Serious Mental Illness*, in INSIGHT AND PSYCHOSIS 269 (Xavier Amador & Anthony S. David eds., 1998).

²⁰⁰ Ilissa L. Watnick, Comment, *A Constitutional Analysis of Kendra's Law: New York's Solution for Treatment of the Chronically Mentally Ill*, 149 U. PA. L. REV. 1181, 1183 (2001).

violence and any number of risk factors—age and violence, gender and violence, income and violence, educational attainment and violence. However, as a general matter, the other-regarding harms we aim to prevent through outpatient commitment are addressed retrospectively, through the criminal justice system. Even if we were able to identify a subgroup of the population as very likely to engage in violence, courts will not impose limits on their freedom in order to prevent the very serious crimes that they are likely to commit. Proponents of the preventable tragedies argument will need to explain why people with mental illnesses should be treated differently.

A. VIOLENCE AND MENTAL ILLNESS

i. COMMUNITY SURVEYS

Several epidemiological studies have found at least a modest association between mental illness and violence. In a seminal study on violence and mental disorder, Jeffery Swanson and colleagues analyzed data drawn from the Epidemiological Catchment Area Study conducted by the National Institute of Mental Health.²⁰¹ As part of the study, 10,000 randomly chosen adults were interviewed to establish the prevalence of mental disorder. Study participants were also asked to self-report violent behaviors during the past year (e.g. injuring a spouse or partner, getting into physical fights, or using a weapon). The study found that schizophrenia, bipolar disorder and major depression were associated with a fourfold increase in the odds of violence within one year, after controlling for sociodemographic variables such as age, gender, socioeconomic status, ethnicity and race. However, the study also found that substance abuse was associated with a far greater risk of violence (odds ratio = 16.8).²⁰²

²⁰¹ Jeffery W. Swanson, *Mental Disorder, Substance Abuse, and Community Violence, an Epidemiological Approach*, in *VIOLENCE AND MENTAL DISORDER* 101 (John Monahan & Henry J. Steadman eds., 1994).

²⁰² *Id.* at 130.

To put these numbers in perspective the authors also estimated the attributable risk violence associated with mental disorder. Since serious mental illnesses are rare, people with a diagnosis of mental disorder alone only accounted for about 4 to 5 percent of the total violence in the population over the course of one year. By contrast, since violence was more common among drug and alcohol abusers, and since there were more substance abusers in the community, the attributable risk of violence among substance abusers was considerably higher, on the order of 27 percent.²⁰³

Findings from the landmark MacArthur Study on Risk Assessment and Violence also underscore the relationship between mental illness, substance abuse and violence.²⁰⁴ The MacArthur Study followed 951 psychiatric patients for one year after they were discharged from acute psychiatric units. In contrast to the Catchment Area Study, researchers used three sources of information to determine the prevalence of violence—interviews with patients, interviews with collateral informants (usually a family member) as well as hospital and arrest records. In the MacArthur study, “violence” included battery that resulted in a physical injury, sexual assault, assault with a weapon or threats with a weapon. Consistent with prior research in this area, substance abuse emerged as an important risk factor for violence. Among patients with both an Axis I mental disorder—e.g. schizophrenia, major depression, or bipolar disorder—and a substance abuse disorder the 1-year prevalence of violence was 31.1%, compared to 17.9% among patients without a substance abuse disorder.²⁰⁵

²⁰³ *Id.* at 118; See also Heather Stuart & Julio E. Arboleda-Florez, *A Public Health Perspective on Violent Offenses Among Persons with Mental Illness*, 52 PSYCHIATRIC SERVICES 654 (2001) (finding that approximately 3 percent of violent offenses could be attributed to individuals who had a principal diagnosis of any non-substance abuse related mental disorder).

²⁰⁴ Henry Steadman et al., *Violence by People Discharged from Acute Psychiatric Facilities and by Others in The Same Neighborhoods*, 55 ARCHIVES OF GEN. PSYCHIATRY. 393 (1998).

²⁰⁵ *Id.* at 399.

Focusing on one study site, Pittsburgh, Pennsylvania, researchers then compared violence among discharged psychiatric patients to the prevalence of violence among others living in the same neighborhood. Once again, substance abuse emerged as a significant risk factor for violence. The study found that discharged psychiatric patients without a substance abuse problem were no more likely to engage in violence than other people living in the same neighborhood without a substance abuse problem. However, the presence of a substance abuse problem raised the prevalence of violence in both groups, particularly among people with a mental disorder. After 1 year, discharged patients with a substance abuse problem were more than twice as likely to report violence, when compared to others in their neighborhood who also had a substance abuse problem. Discharged patients were also more likely to report drug and alcohol abuse than community controls.²⁰⁶

ii. PSYCHOSIS AND VIOLENCE

Subsequent studies have asked whether particular symptoms of psychosis might be associated with violence. In a 1992 study, Bruce Link and colleagues compared arrest rates and self-reported acts of violence among psychiatric patients, residing in the Washington Heights area of New York City, to people who had never received mental health treatment, residing in the same neighborhood.²⁰⁷ The study found that 15 percent of the community sample who had never received treatment from a mental health professional reported fighting within the last 5 years,

²⁰⁶ *Id.* at 400; see also Eric B. Elbogen & Sally C. Johnson, *The Intricate Link between Violence and Mental Disorder*, 66 ARCHIVES OF GEN. PSYCHIATRY 152 (2009) (finding that incidence of violence was higher for people with severe mental illnesses but only significantly so for people with a co-occurring substance abuse or substance dependence disorder); E. Fuller Torrey, Jonathan Stanley, John Monahan, Henry J. Steadman and the MacArthur Study Group, *The MacArthur Violence Risk Assessment Study Revisited: Two Views Ten Years After Its Initial Publication*, 59 PSYCHIATRIC SERVICES 147 (2008) (debating design of the MacArthur Study); Sally Satel & D.J. Jaffe, *Violent Fantasies*, 52 NAT'L. REV. 62 (1998) (for a critique of the MacArthur Study).

²⁰⁷ Bruce G. Link et al., *The Violent and Illegal Behavior of Mental Patients Reconsidered*, 57 AM. SOC. REV. 275 (1992).

compared to 29 percent of repeat psychiatric patients. Link and colleagues then controlled for psychotic symptoms using a scale derived from the Psychiatric Epidemiology Research Interview (PERI). After controlling for psychotic symptoms, the study found that being a repeat psychiatric patient was no longer a statistically significant predictor of violence. Instead, much of the difference between psychiatric patients and community controls could be explained by the level of psychotic symptoms.²⁰⁸ Moreover, even among residents who had never been treated for a psychiatric disorder, psychotic symptoms were associated with violence.

In further analyses Link and colleagues found that three symptoms of psychosis termed “threat/ control-override” symptoms were associated with significant increases in violent behavior, even after controlling for sociodemographic variables and other psychotic symptoms.²⁰⁹ The symptoms included feeling that your mind has been dominated by forces beyond your control, that thoughts put into your head were not your own, and that people wished to do you harm.²¹⁰ Similarly, using data from the Epidemiological Catchment Area Study, Jeffery Swanson and colleagues found that respondents who reported one or more threat/control-override symptoms were more than twice as likely to report violence during the previous year, compared to respondents who reported other psychotic symptoms, and six times more likely to report violence compared to people without a mental disorder.²¹¹

²⁰⁸ *Id.* at 288.

²⁰⁹ Bruce G. Link & Ann Stueve, *Psychotic Symptoms and the Violent/Illegal Behavior of Mental Patients Compared to Community Controls*, in *VIOLENCE AND MENTAL DISORDER* 137 (John Monahan & Henry J. Steadman eds., 1994).

²¹⁰ *Id.* at 143; see also Bruce Link & Ann Stueve, *Psychotic Symptoms and Violent Behaviors: Probing the Components of the “Threat/Control-Override” Symptoms*, 33 *SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY* S55 (1998)(finding that both threat and control-override delusions predicted were independently associated with violent behavior).

²¹¹ Jeffery W. Swanson et al., *Psychotic Symptoms and Disorders and The Risk of Violent Behavior in The Community*, 6 *CRIM. BEHAV. & MENTAL HEALTH* 309 (1996).

However, as Link and colleagues caution, when compared to the risk of violence associated with age, gender and socioeconomic status, the risk of violence associated with psychotic symptomatology is relatively modest.²¹² For example, gender was far more predictive of arrests, fighting, and ever hurting someone badly than status as a former or repeat psychiatric patient.²¹³ Moreover, not all studies have found an association between psychotic symptoms and violence. Some studies, including analyses using ECA data, have not found an association between TCO symptoms and violence when controlling for the effects of treatment noncompliance or the presence of a substance abuse disorder.²¹⁴ Using data from the MacArthur Study, Paul Appelbaum and colleagues found that delusions were not associated with an increased risk of violent behavior, nor were particular threat/control-override (TCO) symptoms associated with a greater risk of violence.²¹⁵ To the contrary, the study found that patients with threat/control-override delusions were significantly less likely to engage in violence than patients without similar delusions. Appelbaum and colleagues note that people who experience chronic psychosis also tend to experience social withdrawal and smaller social networks. The authors hypothesize that with smaller

²¹² Link et al., *supra* note 207, at 290.

²¹³ See also Eric B. Elbogen & Sally Johnson, *The Intricate Link between Violence and Mental Disorder*, 66 ARCHIVES OF GEN. PSYCHIATRY 152 (2009) (finding that mental illness alone did not predict future violence; however, age, gender, having less than a high school education, a history of violence, and juvenile detention, accounted for one quarter of the variance in violent behavior).

²¹⁴ Jeffery Swanson et al., *Violence and Severe Mental Disorder in Clinical and Community Populations: The Effects of Psychotic Symptoms, Comorbidity, and Lack of Treatment*, 60 PSYCHIATRY 1 (1997).

²¹⁵ Paul Appelbaum et al., *Violence and Delusions: Data from the MacArthur Violence Risk Assessment Study*, 157 AM. J. OF PSYCHIATRY 566 (2000); see also Thomas Stompe et al., *Schizophrenia, Delusional Symptoms, and Violence: The Threat/Control-Override Concept Reexamined*, 30 SCHIZOPHRENIA BULLETIN 31 (2004) (finding that threat/control-override symptoms were not associated with violence in a retrospective study of male offenders with schizophrenia).

social networks, people who experience chronic psychosis might have fewer interpersonal interactions, and thus fewer relationships that might lead to violence.²¹⁶

B. RISK ASSESSMENT AND VIOLENCE

Most studies suggest that by itself mental illness is at best a poor predictor of violence. Instead, situational and demographic factors such as being young, male and unemployed with a history of violence appear to be better predictors.²¹⁷ Even then, predictions of violence are notoriously difficult. Owing to the low base rate of violent crime, even the best methods will produce a large number of false positives. For example, a well known study on risk assessment and violence, conducted by Charles Lidz and colleagues, found that clinical predictions of violence were only slightly better than chance.²¹⁸ The research team recruited psychiatric patients from the emergency room of a metropolitan hospital. Researchers then asked clinicians to assess the likelihood that patients would be violent toward others during a 6 month follow up period in the

²¹⁶ See also Sue Estroff et al., *The Influence of Social Networks and Social Support on Violence by Persons with Serious Mental Illness*, 45 HOSP & COMMUNITY PSYCH. 669 (finding that respondents with larger networks, and those whose networks primarily consisted of relatives, were more likely to threaten violence). For more on the relationship between command hallucinations and violence see Louise G. Brahm et al., *Acting on Command Hallucinations and Dangerous Behavior: A Critique of the Major Findings in the Last Decade*, 24 CLINICAL PSYCHOL. REV. 513 (2003). We often think that when people with mental illnesses, like schizophrenia, experience a command hallucination they tend to comply, unthinkingly in lockstep; however, the relationship between command hallucinations and violence appears to be a complicated one, mediated by multiple psychological processes, including—beliefs about the voice, the content of the command, and the consequences of noncompliance.

²¹⁷ See Jeffery Swanson et al. *Violent Behavior Preceding Hospitalization Among Persons with Severe Mental Illness*, 23 LAW & HUMAN BEHAVIOR 185 (while clinical diagnosis and symptom variables were not significantly associated with violence, violent behavior among revolving door patients was associated with substance abuse, young age, a history of victimization); See also Jeffery Swanson, Marvin Swartz et al., *The Social-Environmental Context of Violent Behavior in Persons Treated for Severe Mental Illness*, 92 AM. J. PUB. HEALTH 1523 (2002) (“psychopathology per se seldom leads to assaultiveness,” but may converge with other risk factors such as violent victimization and exposure to violence to increase the risk of violent behavior); Virginia Hiday, *The Social Context of Mental Illness and Violence*, 36 J. HEALTH & SOC. BEHAVIOR 122 (1995); Sue Estroff et al. *The Influence of Social Networks and Social Support on Violence by Persons with Serious Mental Illness*, 45 HOSPITAL & COMMUNITY PSYCHIATRY 669 (1994).

²¹⁸ Charles W. Lidz et al., *The Accuracy of Predictions of Violence to Others*, 269 J. AM. MED. ASS’N 1007 (1993).

community. Clinicians accurately identified 60% of patients who turned out to be violent and 58% of patients who turned out to be nonviolent.²¹⁹ As a result, the study reported a considerable number of false negatives and false positives. One hundred ninety patients who were not predicted to be violent were in fact violent, and one hundred sixty-seven patients who were predicted to be violent during the study period did not engage in violence.²²⁰

A second approach to risk assessment uses statistical or actuarial methods to assess the risk of violence. While clinical approaches to risk assessment depend on a clinician to estimate the risk of violence based on his or her clinical judgment, actuarial methods are based on a standardized list of validated risk factors, such as age, gender and past history of violence. Most studies have shown that actuarial methods tend to be more accurate than clinical predictions.²²¹ For example, using data from the Lidz study, William Gardner and colleagues found that actuarial methods had lower false positive rates and lower false negative rates when compared to clinical prediction.²²² Actuarial predictions based only on the patient's history of violence were also more accurate than clinical predictions of violence. Using only the patient's history of violence, an actuarial model was able to identify 71% of patients who were violent, while clinical methods only identified 62% of patients who engaged in violence.²²³

²¹⁹ *Id.* at 1009.

²²⁰ *Id.*

²²¹ William M. Groove & Paul Meehl, *Comparative Efficiency of Informal (Subjective, Impressionistic) and Formal (Mechanical, Algorithmic) Prediction Procedures: The Clinical-Statistical Controversy*, 2 PSYCHOL. PUB. POL'Y & L. 293 (1996).

²²² William Gardner, Charles Lidz et al., *Clinical Versus Actuarial Predictions of Violence in Patients with Mental Illnesses*, 64 J. Consulting & Clinical Psychol. 602 (1996).

²²³ *Id.* at 607.

What do these findings imply for Kendra's Law and assisted outpatient treatment? First, although several studies have shown that actuarial risk assessments tend to be more accurate than clinical predictions, Kendra's Law does not require an actuarial assessment, nor are actuarial methods often used, since they can be time-consuming and cumbersome.²²⁴ Second, as David Cooke and Christine Michie argue, "it is a statistical truism that "the mean of a distribution tells us about everyone and no one."²²⁵ Actuarial assessments estimate the likelihood of future violence based on the behavior of a group. However, any significant social, psychological or environmental differences between the individual and the group can increase or decrease the likelihood of violence.²²⁶ Third, studies consistently show that a history of violence, and in particular, a recent overt act of violence, are among the best predictors of future violence.²²⁷ However, Kendra's Law does not require a recent act of violence. Under Kendra's Law, a court may order outpatient commitment if, in addition to proof on all other elements, a history of treatment noncompliance has resulted in one of more acts of violence toward others within the last forty-eight months, or even a threat or attempt at serious physical harm toward others within the last forty-eight months.²²⁸

For people with serious and persistent mental illnesses, being misclassified as dangerous can have serious consequences. Even when participation in an assisted outpatient treatment program

²²⁴ John Monahan et al. *Developing a Clinically Useful Actuarial Tool for Assessing Violence Risk*, 176 BRIT. J. PSYCHIATRY 312 (2000).

²²⁵ David J. Cooke & Christine Michie, *Limitations of Diagnostic Precision and Predictive Utility in the Individual Case: A Challenge for Forensic Practice*, 34 LAW & HUM BEHAVIOR 259 (2010).

²²⁶ JOHN PARRY, CIVIL MENTAL DISABILITY LAW, EVIDENCE AND TESTIMONY 669 (2010).

²²⁷ See Douglass Mossman et al., *Risky Business Versus Overt Acts: What Relevance Do "Actuarial," Probabilistic Risk Assessments Have for Judicial Decisions on Involuntary Psychiatric Hospitalizations?* 11 HOUS. J. HEALTH L. & POL'Y 365 (2011).

²²⁸ N.Y. MENTAL HYG. LAW § 9.60 (c)(2)(4)(i) – (ii) (2006).

offers a less restrictive alternative to hospitalization, a court order to participate in group therapy for several hours a day, several days a week, burdens the liberty interests of persons who are predicted to be violent, but in fact, not violent. Courts will sometimes order an assertive community treatment teams to visit the patient's home, further burdening the patient's interest in privacy. There are also system wide costs. With an overemphasis on dangerousness, states risk diverting limited resources toward programs for people with mental illnesses who are thought to be dangerous, and away from the majority of people with mental illnesses who are not dangerous.²²⁹

C. THE CRIMINAL CIVIL DISTINCTION

Suppose, however, that at least when combined with a substance abuse disorder, mental illness gives us good reason to suspect a heightened risk of violence. In addition, we are able to predict violence to a reasonable degree of certainty. What justifies assisted outpatient treatment based on our suspicion that, at some point in the future, the subject of a court order might harm others before he has actually done so? As a general matter the other-regarding harms we aim to prevent through outpatient commitment are addressed through the deterrent and retributive functions of the criminal justice system.

The Supreme Court has yet to address the constitutionality of outpatient commitment. However, in a series of sex offender cases—*Kansas v. Hendricks* and *Kansas v. Crane*—the Court addressed an analogous problem that arises when states use civil commitment to detain sex offenders, beyond the expiration of their sentences, on the ground that they suffer from a mental abnormality and they present a serious danger to others.²³⁰ In both cases, the Court narrowed the

²²⁹ Jeffery W. Swanson, et al., *Robbing Peter to Pay Paul: Did New York State's Outpatient Commitment Program Crowd Out Voluntary Services?* 61 PSYCHIATRIC SERVICES 988 (2010).

²³⁰ *Kansas v. Hendricks*, 521 U.S. 346 (1997); *Kansas v. Crane*, 534 U.S. 407 (2002).

class of offenders eligible for civil commitment to those whose “mental abnormality” rendered them dangerous beyond their control. Writing for the Court in *Crane*, Justice Breyer put it this way:

It is enough to say that there must be proof of serious difficulty in controlling behavior. And this, when viewed in light of such features of the case as the nature of the psychiatric diagnosis and the severity of the mental abnormality itself, must be sufficient to distinguish the dangerous sexual offender whose serious mental illness, abnormality, or disorder subjects him to civil commitment from the dangerous but typical recidivist convicted in an ordinary criminal case.²³¹

Echoing *Hendricks*, Justice Breyer added that the distinction is a necessary one “lest civil commitment [should] become a mechanism for retribution or general deterrence—functions properly those of criminal law, not civil commitment.”²³² What should we make of the holdings in *Hendricks* and *Crane*? What do they imply for outpatient commitment?

In both *Hendricks* and *Crane*, the Supreme Court reaffirmed the criminal justice system as the preferred approach to garden variety criminal conduct. The underlying assumption of the criminal law is that most of us have at least a normal capacity to understand what the law requires, and most of us have at least a normal capacity to order our conduct within the wide boundaries set by legal norms. When culpable agents breach legal norms of their own volition, we speak of “crime” and “punishment,” rather than “breach” and “liability.”²³³ In doing so, we communicate reprobation for wrongdoing, while also addressing the offender as a moral agent. By contrast, the moral legitimacy of civil commitment rests on its limitation to persons who lack the capacities for moral responsibility. As Allen Buchanan and Dan Brock write, “[i]f the dangerous mentally ill are

²³¹ *Crane*, 534 U.S. at 413.

²³² *Id.* at 412.

²³³ Paul H. Robinson, *Foreword: The Criminal-Civil Distinction and Dangerous Blameless Offenders*, 83 J. CRIM. L. & CRIMINOLOGY, 693 (1993).

justifiably treated differently, it must be because they are not capable of responsibly controlling their behavior that is dangerous to others as required by criminal prohibitions.”²³⁴

In the same way, the Supreme Court limited sex offender commitments to those whose mental abnormalities rendered them unable to control their behavior. Even so, critics argue that the Court’s inability-to-control formulation is vastly overbroad and unworkable. As Christopher Slobogin writes, “evidence that the impulses experienced by addicts, sexual offenders and people with psychosis are stronger than those that lead people to commit typical crime is hard to come by; burglars recidivate at least as much as sex offenders, and white collar criminals are probably just as ‘driven’ by urges, albeit for things like wealth, fame or power rather than (or perhaps in addition to) drugs or sex.”²³⁵ To that end, a second approach rejects the volitional impairment approach entirely. Adherents to this view, foremost among them, Eric Janus, Robert Schopp and Stephen Morse, argue that police power commitments are appropriate, but only for those who are, in essence, “too sick to deserve punishment.”²³⁶ As Stephen Morse writes, “[f]or reasons much studied and theorized about, but in fact not very well understood, some unfortunate people are so irrational, so grossly out of touch with reality, that ascribing responsibility to them is a travesty according to any but the most extravagantly libertarian account of human agency.”²³⁷ If under the grip of delusional beliefs such an

²³⁴ ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 329 (1990).

²³⁵ CHRISTOPHER SLOBOGIN, MINDING JUSTICE: LAWS THAT DEPRIVE PEOPLE WITH MENTAL ILLNESSES OF LIFE AND LIBERTY, 131 (2006).

²³⁶ Eric S. Janus, *Hendricks and the Moral Terrain of Police Power Civil Commitment*, 4 PSYCHOL. PUB. POL’Y & L. 297, 298, quoting *Millard v. Harris*, 406 F.2d 964, 969 (D.C. Cir. 1968).

²³⁷ Stephen Morse, *Blame and Danger: An Essay on Preventive Detention*, 76 B.U.L. REV. 123 (1996).

agent were to strike out at a perceived threatener, she would not be morally responsible for her actions, and therefore not deserving of legal punishment.

My own view, to be developed in Part VI, rests on a combination of both approaches. Under certain circumstances, outpatient commitment may be appropriate for people with mental illnesses who are irrational in the way Morse suggests. Alternatively, outpatient commitment might be appropriate for people with mental illnesses who are unable to control their behavior. Before offering an alternative approach to assisted outpatient treatment determinations, Part IV will consider further justifications for outpatient commitment.

IV. HARM TO SELF

A more promising line of argument rests the justification for outpatient commitment on the harm that untreated mental illness presents to oneself. Ordinarily, when we speak of harms associated untreated mental illnesses, we are concerned with harms to welfare interests. On any given night in the United States roughly 600,000 people are homeless and 2 million are homeless at some point during the year. According to the Substance Abuse and Mental Health Services Administration, between one quarter and one third of them have a serious mental illness, primarily schizophrenia, bipolar disorder, or severe depression.²³⁸ Studies have also shown that for people with severe and persistent mental illnesses, the failure to comply with prescribed medications can increase the risk of homelessness.²³⁹ For others, treatment noncompliance will lead predictably to

²³⁸SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., BLUEPRINT FOR CHANGE: ENDING CHRONIC HOMELESSNESS FOR PERSONS WITH SERIOUS MENTAL ILLNESS AND CO-OCCURRING SUBSTANCE ABUSE DISORDERS, DHHS Pub. No. SMA-04-3870, (Rockville, MD: Center for Mental Health Services, Substance Abuse & Mental Health Services Admin., 2003).

²³⁹ Mark Olfson, *Predicting Medication Noncompliance After Hospital Discharge Among Patients with Schizophrenia*, 51 PSYCHIATRIC SERVICES 216 (2000).

incarceration. Of the nearly 2 million inmates held in jails and prisons, an estimated 300,000 suffer from a major mental illness.²⁴⁰ Left untreated people with severe and persistent mental illnesses are also much more likely to commit suicide.²⁴¹

A second line of argument concerns harms related to the ultimate goals or aspirations of people with mental illnesses. For example, the legislative findings for Kendra's Law note that while there are some people with mental illnesses who are capable of living safely in the community with the help of family and friends, there are others who "without routine care and treatment, may relapse and become violent or suicidal, or require rehospitilization."²⁴² Therefore an important goal of the assisted outpatient treatment program is to "restore patients' dignity" and "enable mentally ill persons to lead more productive and satisfying lives."²⁴³ In the same way proponents of Kendra's Law argue that court ordered outpatient treatment is justifiable to the extent that it allows revolving door patients "to actualise their positive liberty."²⁴⁴ Where negative liberty refers to the right to be left alone, or freedom from undue interference, in these accounts, positive liberty refers to the capacity for self-governance, and the ability to set goals and meet them without being dominated by internal constraints. What should we make of these claims?

²⁴⁰ Fred E. Markowitz, *Mental Illness, Crime and Violence: Risk, Context and Social Control*, 16 AGGRESSION & VIOLENT BEHAV. 36 (2011); *See also* Paula M. Dittion, MENTAL HEALTH AND THE TREATMENT OF INMATES AND PROBATIONERS, BUREAU OF JUSTICE STATISTICS: A SPECIAL REPORT (1999).

²⁴¹ Brian Kenneth Ahmedani et al., *Suicide Thoughts and Attempts and Psychiatric Treatment: Informing Prevention Strategies*, 63 PSYCHIATRIC SERVICES 186 (2012).

²⁴² N.Y. MENTAL HYG. LAW § 9.60, Historical and Statutory Notes.

²⁴³ *Id.*

²⁴⁴ Eric Dale, *Is Supervised Community Treatment Ethically Justifiable?* 36 J. MED. ETHICS 271 (2010).

In 2005 John Dawson and colleagues interviewed a small group of psychiatric patients in New Zealand.²⁴⁵ For some, involuntary treatment marked an important, albeit paradoxical, step toward freedom. While community treatment orders were associated with decreases in negative liberty, for some patients, community treatment also appeared to improve positive liberty. Patients reported that treatment orders facilitated independence from the hospital and generally brought them back into society where they were able to do the things that mattered to them—hold down a decent job, be a better husband or a “normal Dad.”²⁴⁶ When a person’s capacity for self-governance is seriously diminished by mental illness, Dawson argues that involuntary outpatient commitment might be justifiable to the extent that it yields improvements in positive liberty.

Efforts to rest the justification for outpatient commitment on retrospective endorsements of treatment are not without their problems. Empirical studies on so-called “thank you theories” of civil commitment have produced mixed results. A large randomized controlled trial of outpatient commitment in North Carolina found little evidence to support a retrospective endorsement theory.²⁴⁷ Instead, as the authors note, most study participants did not endorse the benefits of outpatient treatment either because they did not believe that outpatient commitment was effective, or because they refused to believe that they needed treatment, or both. Moreover, in pressing these arguments, supporters of outpatient commitment overlook the paradox of positive liberty that Isaiah Berlin describes. The paradox rests on the idea of a divided self—a dominant self identified with reason, my ideal, myself at its best, and an empirical self—“swept by every gust of desire and passion

²⁴⁵ John Dawson, *Concepts of Liberty in Mental Health*, 12 OTAGO L. REV. 23 (2009).

²⁴⁶ *Id*; see also Harold Schwartz et al., *Autonomy and the Right to Refuse Treatment: Patients’ Attitudes After Involuntary Medication*, 39 HOSP. & COMMUNITY PSYCHIATRY 1049 (1988) (arguing that for most patients, the decision to refuse medications is a manifestation of their illness and does not reflect autonomous decision making).

²⁴⁷ Marvin Swartz et al., *Endorsement of A Personal Benefit Among Persons with Severe Mental Illness*, 9 PSYCH. PUB. POL’Y & L. 70, 91 (2003).

needing to be rigidly disciplined if it is ever to rise to the full height of its ‘real’ nature.”²⁴⁸ With this division in mind, we may come to think of ourselves as merely assisting others in pursuit of their ideal self, in furtherance of their own interest, and for their own sake, not our own. “Once I take this position,” Berlin writes, “I am in a position to ignore the actual wishes of men...to bully, oppress, torture them in the name, and on behalf of their ‘real’ selves.”²⁴⁹

V. IMPAIRED INSIGHT

One might think that court ordered participation in an AOT program under Kendra’s Law is justified by virtue of the fact that unlike people with general medical conditions, people with mental illnesses lack the capacity to make treatment decisions on their own. Therefore courts may order outpatient treatment for them. However, not all people with mental illnesses are unable to make competent treatment decisions and Kendra’s Law does not require evidence of incompetence.²⁵⁰ Instead supporters of Kendra’s Law argue that outpatient commitment should be considered for anyone with a severe psychiatric disorder who lacks insight into his or her illness, and is at risk of harming themselves or others.²⁵¹

In psychiatry, the term “insight” generally refers to the patient’s awareness that he or she is suffering from an illness. In an early and influential paper on the psychopathology of insight,

²⁴⁸ ISAIAH BERLIN, TWO CONCEPTS OF LIBERTY 45 (1958).

²⁴⁹ *Id.* at 47.

²⁵⁰ See, e.g. Paul S. Appelbaum & Thomas Grisso, *MacArthur Treatment Competence Study: Mental Illness and Competence to Consent to Treatment*, 19 L. & HUM BEHAV. 105 (1995) (finding that most people who have been hospitalized for serious mental illness have similar abilities to make treatment decisions, when compared to people without a major mental illness).

²⁵¹ E. FULLER TORREY & MARY ZDANOWICZ, *Outpatient Commitment: What, Why and for Whom?* 52 PSYCHIATRIC SERVICES 337 (2001).

Aubrey Lewis described insight as “a correct attitude toward morbid change in oneself.”²⁵² Modern approaches describe insight along similar dimensions: (i) the patient’s recognition that he or she has a mental illness; (ii) the ability to relabel unusual events, such as delusions and hallucinations, as pathological; and (iii) compliance with treatment.²⁵³ In the debate surrounding Kendra’s Law, evidence regarding the biological basis of impaired insight has played an important role in the justification for assisted outpatient treatment. E. Fuller Torrey and Mary Zdanowicz write:

We argue that outpatient commitment is needed because many individuals with severe psychiatric illness lack awareness of their illness. This deficit is biologically based and is not the same thing as psychological denial. Both schizophrenia and bipolar disorder affect the prefrontal cortex, which is used for insight and understanding one’s needs. When this area of the brain is damaged, the person loses self-awareness.²⁵⁴

Torrey and Zdanowicz are outspoken proponents of Kendra’s Law. Torrey and Zdanowicz argue that impaired illness awareness, common among patients with schizophrenia, resembles anosognosia among patients with neurological disorders such as Alzheimer’s disease, or patients who have suffered a stroke. In classic cases of anosognosia, paraplegic patients who have suffered damage to the right hemisphere of the brain will deny that they are paralyzed on the left side of the body. When confronted with the affected limb, anosognostic patients may insist that the limb is not their own or express indifference in response to their paralysis.²⁵⁵ In the same way, it is not uncommon for

²⁵² Aubrey Lewis, *The Psychopathology of Insight*, 14 BRIT. J. PSYCHOL. 333 (1934). *See also*, Anthony S. David, “To See Ourselves as Others See Us,” 175 BRIT. J. PSYCHOL. 210 (1999).

²⁵³ Anthony S. David, *Insight and Psychosis*, 156 BRIT. J. PSYCHIATRY 798 (1990); *see also* Xavier F. Amador & David H. Strauss, *The Scale to Assess Unawareness of Mental Disorder (SUMD)*. Columbia University and the New York State Psychiatric Institute (operationalizing insight along four dimensions: awareness of (1) having a mental disorder; (2) the effects of medication; (3) the consequences of mental disorder, and (4) the specific signs and symptoms); *see generally* XAVIER AMADOR & ANTHONY DAVID eds., *INSIGHT AND PSYCHOSIS* (2004).

²⁵⁴ TORREY & ZDANOWICZ, *supra* note 251, at 338.

²⁵⁵ XAVIER AMADOR & ANTHONY DAVID eds., *INSIGHT AND PSYCHOSIS* 22 (1998).

patients with schizophrenia to deny the symptoms of mental illness. A study by Xavier Amador and colleagues assessed more than 400 patients with psychotic disorder and found that nearly 60% of patients with schizophrenia were unaware of having a mental illness. When asked whether they had any mental, psychiatric or emotional problems, most patients answered an emphatic “no.”²⁵⁶ When compared to patients with bipolar disorder or schizoaffective disorder, patients with schizophrenia were also less likely to acknowledge specific symptoms of mental disorder, including delusions, hallucinations, thought disorder and blunted affect.

Torrey and Zdanowicz further argue that impaired illness awareness is biologically based, and therefore distinguishable from mere psychological denial. For Torrey and Zdanowicz, the neurobiological basis of impaired illness awareness furnishes a critical distinction between people with mental illnesses and other people with general medical conditions who sometimes refuse treatment. As the authors write: we can assume that when people with heart disease or arthritis refuse treatment, “their cognitive functioning and awareness of their illness are intact,” however, “one cannot make this assumption about an individual who has a severe psychiatric disorder.”²⁵⁷ In the same way, other supporters of outpatient commitment argue that community treatment orders are justified for those whose “brain disorders prevent them from making an informed decision.”²⁵⁸

Although plausible, arguments along these lines are not without their problems. While several studies have found a significant correlation between impaired insight and poor performance

²⁵⁶ Xavier Amador et al., *Awareness of Illness in Schizophrenia*, 51 SCHIZOPHRENIA BULLETIN 826 (1994).

²⁵⁷ TORREY & ZDANOWICZ, *supra* note 251, at 338.

²⁵⁸ Eric Dale, *Is Supervised Community Treatment Ethically Justifiable?* 36 J. MED. ETHICS 271 (2010).

on tests of frontal lobe function, these correlations tend to be relatively modest.²⁵⁹ Moreover, while many studies have found an association between poor insight and impaired frontal lobe function, many others have not.²⁶⁰ Instead, studies suggest that there are multiple pathways to impaired insight, and many of them have little to do with neuropsychological impairment. In some instances, a denial of mental illness may result from psychological denial regarding the severity of symptoms.²⁶¹ In other instances, a person might deny that he has a mental illness because he believes that he has been wrongly diagnosed with a mental illness or at the very least misdiagnosed. For the same reasons, a person might deny the benefits of treatment or understate the consequences of refusing treatment because in his experience he has been overmedicated or inappropriately medicated. We know that African American men—who are often the subject of court ordered outpatient treatment—are significantly more likely to be misdiagnosed with schizophrenia, giving them good reason to challenge their diagnoses and the benefits of treatment in court.²⁶²

Even when a person is prepared to acknowledge troubling or distressing symptoms to himself, the stigma surrounding the term “mental illness” can sometimes cause a person to deny that his experience is properly classified as a mental illness. For others, a denial of mental illness will

²⁵⁹ See IVANA MARKOVÁ, *INSIGHT IN PSYCHIATRY* 103-09 (2005) (for a review of the empirical literature on insight and psychosis).

²⁶⁰ See e.g. Alisa Mintz et al., *Insight in Early Psychosis: A 1-Year Follow-Up*, 61 *SCHIZOPHRENIA RES.* 75 (2004) (finding no association between insight and cognition at baseline or at follow up); see also Luca Arduini et al., *Insight and Neuropsychological Function in Patients with Schizophrenia and Bipolar Disorder with Psychotic Features*, 48 *CANADIAN J. PSYCHIATRY* 338 (2003) (finding no association between insight and cognitive variables).

²⁶¹ Michael Startup, *Awareness of One's Own and Others' Schizophrenic Illness*, 26 *SCHIZOPHRENIA RES.* 203; See also Lysaker et al., *Patterns of Neurocognitive Deficits and Unawareness of Illness in Schizophrenia*, 191 *J. NERVOUS & MENTAL DISEASE* 38 (2003) (positing that subgroups of patients with poor insight may show poor insight for different reasons including poor cognition and poor reality testing as well as a tendency to deny unpleasant things).

²⁶² See Arnold Barnes, *Race and Hospital Diagnoses of Schizophrenia and Mood Disorders*, 53 *SOC. WORK* 77 (2008); See generally JONATHAN MENZEL, *THE PROTEST PSYCHOSIS: HOW SCHIZOPHRENIA BECAME A BLACK DISEASE* (2011).

stem from fundamental differences of opinion about what it means to have an “illness.” Whether a person understands himself as ill will depend on his experience of what it means to be ill, the meaning of the term “illness” in the world around him, and his observation of others who have been classified as ill.

Evidence regarding impaired insight often plays a key role in assisted outpatient treatment hearings. Although Kendra’s Law does not use the term “insight,” court ordered outpatient treatment requires evidence that “as a result of his or her mental illness,” the subject of a petition for AOT is unlikely to participate in outpatient treatment voluntarily.²⁶³ To that end, it is not uncommon for clinicians to reference poor insight as evidence that the person is unlikely to cooperate with outpatient treatment absent court ordered supervision. However, clinical judgments regarding the patient’s level of insight may be extraordinarily difficult to challenge in court since patients’ accounts of their own illness are routinely discounted.²⁶⁴ Judgments about insight may also depend on the patient’s attitudes toward treatment and whether patients agree with their diagnosis. During an interview, an attorney for the Mental Hygiene Legal Service expressed her frustration: When respondents are asked whether they have a mental illness, “doctors are looking for a very specific answer to that question” even though many of her clients would prefer to describe their symptoms as the product of a “chemical imbalance,” or anything other than a mental illness.²⁶⁵

The same attorney wondered whether her clients would ever be able to verbalize the symptoms of their mental illnesses in a way that would convince the court of their insightfulness. It

²⁶³ N.Y. MENTAL HYG. LAW § 9.60 (c)(5)(2006).

²⁶⁴ Dariusz Galasinski & Konrad Opalinski, *Psychiatrists’ Accounts of Insight*, QUALITATIVE RES., first published on June 28, 2012 (e-pub ahead of print) available at <http://www.ncbi.nlm.nih.gov/pubmed/18610823> (last visited Sept. 5, 2012).

²⁶⁵ Interview with Jane Doe, Attorney, Mental Hygiene Legal Service, in New York, N.Y. (June 15, 2011) (on file with author).

may be that we underestimate what it would require to enter a courtroom, sit before a judge and make an oral argument on one's own behalf. The ideal respondent would describe her symptoms in detail, eloquently remarking on the textbook definition of her illness, and her particular illness experience. However, when respondents fall short of this standard, what are we really hearing? How much of their lack luster testimony is the result of poor education, lack of preparation, anxiety, or the foreignness of the forum and the foreignness of the task itself? Instead the attorney felt that what should matter in these proceedings is whether her clients are actually complying with treatment. However, even if insight were a function of the respondent's behavior, during an AOT renewal hearing it would be incredibly difficult for the respondent to convince the court that a period of treatment compliance during the proceeding AOT order was the result of greater insight. The problem for the court is simple—how can a judge know whether a period of treatment compliance was the product of greater insight or the threat of a 72 hour hospitalization? In Part VI I argue that we should reject impaired insight as a measure of diminished mental capacity and instead limit assisted outpatient treatment to people with mental illnesses who are unable to make competent treatment decisions on their own.

VI. COMPETENCE TO REFUSE TREATMENT

As Alan Buchanan and Dan Brock have observed, competence is always competence “to do something,” at a particular time, under particular circumstances; therefore, the appropriate concept of competence is a decision-relative and a variable one.²⁶⁶ Second, as Buchanan and Brock rightly argue, settling on an appropriate competence standard is not simply a matter of settling on the

²⁶⁶ ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING 18 (1990).

correct test, but rather a process of balancing competing values and guarding against two kinds of error. The first error (Type I or false positive) results from choosing a standard of competence that is too low, and failing to protect the person from the harmful consequences of his or her decisions, when those decisions stem from serious defects in the capacity to decide. The second error (Type II or false negative) results when we choose a threshold for competence that is too high and we fail to allow a person to make her own choices when she is able to do so.²⁶⁷

For the person whose competence is being assessed, the right to accept or refuse outpatient treatment will often hold a combination of instrumental and non-instrumental value. As Brock and Buchanan write, although the physician brings her knowledge of medicine and health to the doctor patient relationship, “health is only one value among many.”²⁶⁸ Once the physician has informed me of the risks and benefits associated with a particular treatment, I am in the best position to determine “which intervention, if any, best serves my wellbeing, as I conceive it.”²⁶⁹ Thus the right to make important treatment decisions may be instrumentally valuable in the promotion of wellbeing. However, even when others are in a better position to make choices for us, most people want to make important choices about their own lives. Often our choices, ranging from the mundane and everyday, to important choices about how to live our lives, have both instrumental and non-instrumental value. For example, choices about medical treatment are likely to have considerable symbolic value.²⁷⁰ Most people who are competent to make decisions about medical

²⁶⁷ *Id.* at 40-41.

²⁶⁸ *Id.* at 30.

²⁶⁹ *Id.*

²⁷⁰ See T.M. Scanlon, The Significance of Choice, The Tanner Lectures on Human Values, Delivered at Brasenose College, Oxford University (May 16, 23, and 28 1986) (discussing the symbolic and demonstrative value of choice).

treatment are permitted to do so. Therefore, I may value choice because without it, I will feel that the absence of choice is degrading. If I am a person of faith, I may value choices regarding medical treatment—including the choice to forego treatment—because it matters to me that I am able to incorporate elements of my faith into healing. In these moments, my choices about treatment may have considerable demonstrative value.

Like most authors on competence, I agree that competence to refuse treatment requires the ability to understand key facts involved in a decision to refuse treatment, the ability to engage in basic reasoning about those facts, the ability to reach a decision and the ability to communicate a stable choice. However, in contrast to other authors on competence, I argue that an emphasis on appreciation or insight as a measure of competence is misplaced.²⁷¹ Instead in Part VI.A I argue for a cognitive approach to assessing competence. When our primary concern is one of self-regarding harm, our only question should be whether the person is competent to refuse treatment. However, Part VI.B. goes on to address a further concern—at times we will worry that refusing outpatient treatment could result in harm to others, not merely in harm to oneself. For reasons similar to those raised by the Court in *Kansas v. Hendricks* and *Kansas v. Crane*, Part VI.B. asserts that when our primary concern is one of other-regarding harm, a court order to participate in assisted outpatient treatment may be appropriate, but only for people with mental illnesses who are unlikely to

²⁷¹ See e.g. THOMAS GRISSO & PAUL S. APPELBAUM, *Abilities Related to Competence*, in *ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* 31 (Oxford University Press, 1998) (recommending four functional abilities as the focus for assessments of competence to consent to treatment, including “the ability to appreciate the significance of information for one’s own situation, especially concerning one’s illness and the probable consequences of one’s treatment options”); See also Kathleen Glass, *Refining Definitions and Devising Instruments: Two Decades of Assessing Mental Competence*, 20 INT’L J. L. & PSYCHIATRY 5, 22 (proposing that “appreciation implies sufficient critical judgment or insight to value the information that has been comprehend” and when emotional or affective factors inhibit the formation a judgment regarding mental health treatment, that assessment should result in a finding of incompetence.); See also Louis C. Charland, *Mental Competence and Value: The Problem of Normativity in the Assessment of Decision-Making Capacity*, 8 PSYCHIATRY, PSYCHOL. & L. 135, 136 (2001)(discussed *infra* p. 22) ; But see Christopher Slobogin, *Appreciation as a Measure of Competency: Some thoughts about the MacArthur Group’s Approach*, 2 PSYCHOL. PUB. POL’Y & L. 18.

appreciate the wrongfulness of their conduct, or those who lack the capacity to conform their conduct to the requirements of the law.

A. HARM TO SELF

i. MODEL RULE: HARM TO SELF

- (a) A person who is competent to refuse outpatient treatment, as defined in section (b) of this rule, shall not be ordered to participate in an assisted outpatient treatment program on the ground that refusing treatment is likely to result in harm to himself.
- (b) A person is competent to refuse outpatient treatment if:
 - (1) he understands the proposed treatment plan and the consequences of refusing treatment;
 - (2) he is able to reason through relevant information; and
 - (3) he is able to communicate a choice.

1. UNDERSTANDING

A person who is competent to refuse treatment must possess at least a rudimentary understanding of the basic features of his illness and the proposed treatment plan. Whether he believes he has an illness or not, and whether he believes that treatment will help him or not, he must at least understand that his physician believes he has an illness and that his physician believes that the recommended treatment could help him. Any less and we would worry that the person is too impaired or too disoriented for us to view his treatment decisions as competent.

As to this element of competence, it should be enough that the person understands his decision in this basic factual sense: he is aware of his medical diagnosis, he can explain it in lay terms, and he understands the proposed treatment plan, as well as the primary risks and benefits associated with treatment. However, most authors on competence think that understanding should

also incorporate a notion of understanding as appreciation or insight.²⁷² For example, Louis Charland writes: “[a]ppreciation consists in an individual’s ability to apply his or her current understanding of a given medical condition to him or herself. It is one thing to understand what schizophrenia is, but quite another to recognise that this information applies to you.”²⁷³ Charland and I are in agreement here, but only in a weak sense. In order to meet the understanding prong of a competence test, it should be enough for a person to understand that a psychiatric assessment is an assessment of him, not some hypothetical person. Charland, however, intends something more. By “recognise” I take Charland to mean “agree” so that a person must agree that he has an illness called schizophrenia. However on the view of competence I am proposing to require agreement on diagnosis would require too much.

Approaches to competence that require some degree of “appreciation” will fail to account for instances of reasonable disagreement. At times, clinicians and patients may agree on most aspects of a case, yet fail to agree on a diagnosis. For example, a person might acknowledge feelings of sadness, fatigue and loss of energy for most of the day, for more than two weeks—and indeed, acknowledge the recurrence of these feelings over time—yet express some ambivalence about whether he has a mental illness. Clinicians and patients will sometimes disagree over whether feelings of sadness and depression are pathological, or merely a normal reaction to external circumstances. Others may feel that their symptoms do not rise to the level of an illness.

²⁷² See e.g. Thomas Grisso & Paul Appelbaum, *The MacArthur Treatment Competence Study III: Abilities of Patients to Consent to Psychiatric and Medical Treatments*, 19 L. & HUMAN BEHAVIOR 147, 155-156 (1995) (discussing subtests of the MacArthur Competence Assessment Tool (MacCAT)—the Nonacknowledgement of Disorder subtest (NOD) and the Nonacknowledgement of Treatment subtest (NOT). While the NOD is designed to assess the extent to which patients acknowledge the existence of their mental disorder, the NOT allows patients to rate their degree of agreement or disagreement in response to statements about their disorder and the potential benefits of treatment).

²⁷³ Louis C. Charland, *Mental Competence and Value: The Problem of Normativity in the Assessment of Decision-Making Capacity*, 8 PSYCHIATRY, PSYCHOL. & L. 135, 136 (2001).

Consider a person who has been diagnosed with schizophrenia. Schizophrenia is a psychotic disorder, characterized by hallucinations, delusions, disorganized speech, and disorganized behavior. Although symptoms of psychosis frequently accompany schizophrenia, a wide variety of medical conditions can include psychotic symptoms, including substance-induced psychosis, delusional disorder and bipolar disorder.²⁷⁴ The positive symptoms of schizophrenia—delusions, hallucinations and paranoia—resemble the symptoms of a mania, while the negative symptoms of schizophrenia—flattened affect, emotional withdrawal and social isolation—can resemble depression, leading clinicians to confuse schizophrenia with bipolar disorder, or vice versa.²⁷⁵ For example, as I noted above African American men tend to be overrepresented among patients who have been diagnosed with schizophrenia and underrepresented among patients who have been diagnosed with bipolar disorder and depression.²⁷⁶ However, large epidemiological surveys designed to measure the prevalence of mental disorders have shown that the prevalence of schizophrenia, bipolar disorder and depression does not vary by ethnicity. The clinical tendency to overdiagnose schizophrenia among African Americans might arise for any number of reasons, ranging from cultural differences in the expression of symptomatology to “the cultural distance” between clinician and patient.²⁷⁷ The result, however, is that a reasonable person might “recognise” that a diagnosis of schizophrenia applies to him, yet insist that he has been wrongly diagnosed nonetheless.

²⁷⁴ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, FOURTH EDITION, TEXT REVISION 297- 298 (2000).

²⁷⁵ Frederic C. Blow et al., *Ethnicity and Diagnostic Patterns in Veterans with Psychoses*, 39 SOC. PSYCHIATRY EPIDEMIOLOGY, 841 (2004).

²⁷⁶ *Supra* note 262.

²⁷⁷ Lloyd H. Rogler, *Framing Research on Culture in Psychiatric Diagnosis: The Case of the DSM-IV*, 59 PSYCHIATRY: INTERPERSONAL & BIOLOGICAL PROCESSES 145, 147 (1996).

2. REASONING AND COMMUNICATION

Competence also requires an ability to reason about treatment and the ability to communicate a choice. What is required here is not perfect rationality, but rather at least a basic ability to reach conclusions that are logically consistent with starting premises.²⁷⁸ Doing so will require an ability to weigh the risks and benefits of treatment against one's values, as well as at least a basic understanding of probabilities. For example, a person who is competent to refuse a recommended course of treatment should understand what it would mean for an outcome to be more likely than not.²⁷⁹

Most authors on competence agree that an assessment of competence should focus on the quality of the reasoning process, rather than the rationality or reasonableness of the outcome.²⁸⁰ Our focus on the quality of the reasoning process should also include limits on the kinds of reasons that are permitted to factor into a competent decision. The problem, of course, lies in determining which reasons to exclude. Some reasons are irrelevant as obvious non-sequiturs and provide ready grounds for exclusion: I am refusing treatment because today is Tuesday.²⁸¹ Other reasons are, to use Elyn Saks' term, "patently and demonstrably false"—Zyprexa is made of green cheese; my psychiatrist is an alien.²⁸² Saks defines patently false beliefs as beliefs that are "so unlikely that even

²⁷⁸ Paul Appelbaum & Thomas Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 NEW ENG. J. MED. 1636 (1988).

²⁷⁹ *Id.*

²⁸⁰ *Id.* See also Benjamin Freedman, *Competence: Marginal and Otherwise*, 4 INT'L J.L. & PSYCHIATRY 53 (1981); Charles M. Culver & Bernard Gert, *The Inadequacy of Competence*, 68 MILLBANK Q. 619 (1990).

²⁸¹ See Freedman, *supra* note 137 at 64.

²⁸² Elyn Saks, *Competency to Refuse Treatment*, 69 N.C. L. Rev. 945, 956 (1991).

the most superficial reading of the data will indicate their falsity.”²⁸³ Patently false beliefs are also distinguishable from simple delusions. To borrow her example, consider a patient who suffers from depression and believes she is a bad person, although others think she is a very good person.²⁸⁴ Her belief may be false and it may be a delusion, but it is not patently or indisputably false. If, on the other hand, she were to believe that she is an evil person because she committed mass murder, even though she had not, such a belief would be patently and demonstrably false. When a person harbors patently false beliefs despite evidence to the contrary, we have good reason to believe that he or she is incapacitated and unable to make competent treatment decisions.

Still, not all of the reasons one might offer for refusing treatment are obviously irrelevant or susceptible to ready proof as patently and demonstrably false. In the first category are factual questions that are susceptible to proof. In the second category are reasons based on beliefs, the most challenging of which may be reasons for treatment refusal based on religious beliefs. Consider the Jehovah’s Witness who refuses a blood transfusion owing to his belief that the Bible prohibits ingesting blood and contains the word of God. We can neither prove nor disprove the existence of God, and yet our commitment to religious pluralism necessitates some allowance for reasons of this kind to factor into treatment decisions.

And yet if we accept faith as a legitimate reason for treatment refusal in these circumstances, how can we distinguish the Jehovah’s Witness from the person who refuses treatment, not owing to his belief in God, but owing to his belief that he *is* God? The Jesus delusion is the most common of all psychiatric delusions, combining both delusions of grandeur and persecution.²⁸⁵ Clinicians

²⁸³ ELYN SAKS, REFUSING CARE: FORCED TREATMENT AND THE RIGHTS OF THE MENTALLY ILL, 187 (2002).

²⁸⁴ *Id.* at 186-7.

²⁸⁵ Alan Gettis, *The Jesus Delusion: A Theoretical and Phenomenological Look*, 26 J. RELIGION & HEALTH 131 (1997).

frequently encounter patients who believe they are Jesus, the Virgin Mary, or other figures of religious or historical importance, and a claim to be any one of them is virtually certain to result in a diagnosis of serious psychopathology.²⁸⁶ For some, the Jesus delusion results from a confusion of similarities and identities—Jesus was a man with a blondish beard. I am a man with a blondish beard; therefore, I am Jesus.²⁸⁷ We can imagine circumstances in which persons come to see themselves as Jesus in a merely metaphorical sense that can be clarified in conversation. In these circumstances, by itself the Jesus delusion would not be sufficient grounds to conclude that a person is incompetent to make treatment decisions. However, I think we want to say that a person who persists in his belief that he is in fact the risen son of God is not competent to make treatment decisions.

When confronted with this question, clinicians will ordinarily ask whether the patient's beliefs predate the treatment decision, whether the patient has previously behaved in ways that are consistent with those beliefs and whether the patient's beliefs are reflective of religious views held by others.²⁸⁸ Insofar as we are interested in determining whether the patient's reasons for refusing treatment reflect genuine religious beliefs, the thought here is that if the beliefs are unconventional or idiosyncratic to the patient, they are more likely to indicate psychopathology. However, in contrast to the dominant medical view, Elyn Saks argues that a normatively desirable standard would afford considerable protection to unconventional or idiosyncratic beliefs. Saks writes that while there may be some limits on what patients can believe, "limits that are too stringent severely curtail

²⁸⁶ *Id* at 132.

²⁸⁷ *Id*.

²⁸⁸ THOMAS GRISSO & PAUL S. APPELBAUM, *ASSESSING COMPETENCE TO CONSENT TO TREATMENT: A GUIDE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS* 48 (1998).

that patients' freedom to be unconventional in their pursuit of truth."²⁸⁹ Since many people hold distorted beliefs, we risk "discriminating against the mentally ill if we disable them based on their distortions."²⁹⁰ Instead Saks draws the line at patently false beliefs, asserting that only patently false beliefs should disqualify a person from competence. How should we think about this? Consider the following case study, involving Ricardo Jesus B.:

Several months before he came to us with a diagnosis of paranoid psychosis, Ricardo Jesus experienced a series of severe epileptic seizures. When the seizures ended, Ricardo developed a psychotic condition. His delusion consisted of the following—during the seizure, epileptic Ricardo died and Jesus B. survived. He, Ricardo, now Jesus B., had been in heaven seated at the right hand of the Father. The sick person, Ricardo who everyone in the village laughed at is dead. In his place Jesus B. survives. Jesus B. is not identical to Jesus Christ, but close to him since they bear the same name. In the hospital, Ricardo was always in a good mood and respected by other patients. One day he asked for a certificate of discharge so politely and with such irreproachable behavior, that we let him leave. He came back to us twice—always glad, emanating a naïve saintliness and telling anyone who wanted to hear him how happy he was to no longer be an epileptic at whom everyone laughed, and how happy he was to spread the good news to mortals, first to his neighbors in the little mountain village where he cares for his goats, and then to anyone else who is willing to receive it.²⁹¹

The case study comes from Ottor Doerr and Óscar Velásquez, in the Department of Psychiatry, University of Chile. I think most of us would say that the doctors who released Ricardo B. were right to do so. With little or no risk of harm to himself, there is no reason to keep him in a hospital. Suppose, however, that instead of spreading the good news to his neighbors, in a little mountain village in Chile, Ricardo B. lives in New York City. He continues to believe that at least in some way, he has been reincarnated as the son of God. Only now, Ricardo B. believes that, like Jesus, God has called upon him to live a life of suffering. So he huddles in abandoned buildings for

²⁸⁹ ELYN SAKS, REFUSING CARE, 182.

²⁹⁰ *Id.*

²⁹¹ Otto Doerr & Óscar Velásquez, *The Encounter with God in Myth and MADNESS*, PHILOSOPHY, ETHICS & HUMANITIES IN MEDICINE, (2007).

warmth with no money, no food and nowhere to go. If we were to accept Elyn Saks' view, then despite a diagnosis of psychosis and despite the obvious risk of harm to himself, courts would have no authority to insist that Ricardo B. participate in treatment, since his sincere belief that he is the son God is neither irrelevant, nor patently and demonstrably false.

By drawing the line at patently false beliefs, Saks protects the right to hold idiosyncratic ideas. However in doing so she also overvalues the interest in autonomy. Autonomy matters—the right to hold idiosyncratic beliefs matters—but it's not the only thing that matters. Settling on the appropriate standard for competence to refuse psychiatric treatment involves a process of balancing competing and at times conflicting values. On the one hand, there are Ricardo B.'s interests in making his own choices about outpatient treatment. On the other hand, we also have an interest in protecting would-be patients from the harmful consequences of their decisions when those decisions stem from serious defects in the capacity to decide. Religious delusions also reside in an ambiguous territory between psychopathology and a merely unusual religious belief. Given the severity of the harm and our uncertainty, a court might reasonably err on the side of caution and order outpatient commitment.

B. HARM TO OTHERS

What should we say about a person who presents a substantial risk of harm to others by virtue of mental illness, but who is competent to refuse treatment nonetheless?

Following a fight with his mother, during which he “accidentally” pushed her to the ground, Gary, a 30-year-old man, was admitted to a psychiatric hospital with a diagnosis of paranoid schizophrenia. According to hospital records, Gary was “malodorous,” and “experiencing bizarre delusions,” including a delusional belief that he was growing extra body parts and being controlled by “Larry,” who “likes to eat people’s organs with a knife and fork.” During an inpatient therapy session, Gary threw a psychiatrist against a wall and struck a resident with his fists, claiming that he was “unable to control his arms.” After a few weeks in the hospital, the symptoms of psychosis improve and Gary files a petition to be released from the hospital. During the hearing, Gary’s mother testifies to Gary’s history of assault, treatment noncompliance and substance abuse following his release from

psychiatric hospitals. Doctors petition the court for assisted outpatient treatment in an effort to prevent a relapse of psychosis that would be likely to result in serious harm to others. Gary, however, refuses to participate in the program.²⁹²

What should we do? Suppose Gary is competent to refuse treatment. He understands the basic features of his illness and the proposed treatment plan. By all accounts his reasons for refusing treatment are neither irrelevant nor demonstrably false, and he is able to communicate a stable choice. Still, I think a fair outpatient commitment program could order Gary to participate in outpatient treatment, notwithstanding a finding of competence. Our challenge, however, will be to distinguish Gary—subject to preventive outpatient commitment—from others whose dangerous behaviors are more appropriately addressed through the criminal justice system.

In both *Kansas v. Hendricks* and *Kansas v. Crane*, the Supreme Court affirmed the deterrent and retributive functions of the criminal justice system as the preferred approach to handling garden variety criminal conduct. And in both cases, the Court held that states may use civil commitment to detain sex offenders beyond the expiration of their sentences when a mental abnormality makes it “difficult, if not impossible for the person to control his behavior.”²⁹³ Yet as I noted above, critics argue that the Court’s impaired control standard is at best confused and overbroad. Instead police power commitments are only appropriate for persons who are grossly irrational by virtue of mental illness or in essence, “too sick to deserve punishment.”²⁹⁴ By retooling the insanity defense, Part VI develops the intuition that persons who are appropriate candidates for outpatient commitment do not qualify for criminal punishment either because they are grossly irrational as Stephen Morse

²⁹² Case study based on Andrew Goldstein, *See* CHARLES EWING, *INSANITY, MURDER, MADNESS AND THE LAW* 114–127 (2008); *IN THE MATTER OF DAVID DIX*, *supra* note 36.

²⁹³ *Kansas v. Hendricks*, 521 U.S. 346, 358 (1997); *Kansas v. Crane*, 534 U.S. 407, 411 (2002).

²⁹⁴ Eric S. Janus, *Hendricks and the Moral Terrain of Police Power Civil Commitment*, 4 *PSYCHOL. PUB. POL’Y & L.* 297, 298, quoting *Millard v. Harris*, 406 F.2d 964, 969 (D.C. Cir. 1968).

argues, or because they are unable to conform their conduct to the requirements of the law. Part VI provides a brief overview of the insanity defense and proposes a model rule.

i. THE INSANITY DEFENSE

The earliest and best known test of criminal insanity is the M’Naghten Rule. Daniel M’Naghten suffered from a delusional belief that he was being persecuted by the Prime Minister of Great Britain, Sir Robert Peel.²⁹⁵ Believing Peel’s assistant Edward Drummond to be Sir Robert Peel, M’Naghten shot and killed Drummond on January 20, 1843. M’Naghten was acquitted by reason of insanity, and in response to the public outrage the House of Lords formulated the M’Naghten Rule. Under the M’Naghten Rule, a person has an insanity defense if, at the time of committing the act, “the party accused was labouring under such a defect of reason, from disease of the mind” as not to know “the nature and quality of the act he was doing, or as not to know that what he was doing was wrong.”²⁹⁶ The M’Naghten Rule was soon criticized for focusing too narrowly on the ability to distinguish right from wrong conduct and overlooking control impairments due to mental disease or defect.²⁹⁷ As a result some jurisdictions supplemented the M’Naghten Rule with an “irresistible impulse” test. Under the M’Naghten-plus-irresistible-impulse test, a person has an insanity defense if—(i) he satisfies the M’Naghten Rule; or (ii) he has “lost the power to choose between right and wrong,” by reason of mental disease or defect, and the alleged crime was so connected to such mental disease or defect as to have been the product of it.²⁹⁸

²⁹⁵ R. v. M’Naghten, 8 E. R. 718 (1843).

²⁹⁶ *Id.* at 722.

²⁹⁷ PAUL ROBINSON, CRIMINAL LAW, 365 (Cahill eds., 2nd ed. 2012).

²⁹⁸ *Id.* at 365; *Parsons v. State*, 2 So. 854 (Ala. 1887).

In 1965 the American Law Institute published the Model Penal Code (MPC). Section 4.01, Mental Disease or Defect Excluding Responsibility, combines elements of the irresistible impulse test and the McNaghten Rule. Under the MPC test:

A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality [wrongfulness] of his conduct or to conform his conduct to the requirements of the law.²⁹⁹

In contrast to the McNaghten Rule and the irresistible impulse test, the Model Penal Code relieves the defendant of criminal responsibility if, as a result of a mental disease or defect, he lacks “substantial capacity” to appreciate the criminality of his conduct or conform his conduct to the requirements of the law. The McNaghten Rule and the irresistible impulse test, on the other hand, appear to require total impairment in the ability to know that one’s conduct was wrong or a total loss in the ability to choose between right and wrong.

The Model Penal Code also allows the defendant to prevail on an insanity defense if he failed to appreciate the “criminality” or “wrongfulness” of his conduct. According to the drafters of the Model Code, “[a]n individual’s failure to appreciate the criminality of his conduct may consist in a lack of awareness of what he is doing or a misapprehension of material circumstances, or a failure to apprehend the significance of his actions in some deeper sense.”³⁰⁰ Given the seriousness of most cases in which defendants assert an insanity defense, the difference between criminality and wrongfulness is unlikely to arise in most situations with only two exceptions.³⁰¹ The difference in wording might matter if the defendant understood an action to be legally prohibited but

²⁹⁹ Model Penal Code § 4.01 (1985).

³⁰⁰ AMERICAN LAW INSTITUTE, MODEL PENAL CODE AND COMMENTARIES PART I §§3.01 to 5.07, 164 (1985).

³⁰¹ *Id.* at 169.

commanded by God or morally justified nonetheless.³⁰² Second, and less likely, it may be that defendant grasps the difference between right and wrong, but as a result of a mental defect, fails to understand the concept of a crime or government prohibition.³⁰³

The Model Penal Code has been widely adopted in the United States. Twelve states and the District of Columbia have adopted the Model Penal Code formulation in its entirety; and nine states, including New York, have adopted the cognitive prong of the Model Penal Code test.³⁰⁴ As a result, a defendant who pleads not guilty by reason of insanity in New York bears the burden of proving by a preponderance of the evidence that he lacked the substantial capacity to know or appreciate either the nature and consequences of such conduct or that such conduct was wrong.³⁰⁵ In contrast to the Model Penal Code, New York does not allow for the possibility that a person might be not guilty by reason insanity if he lacked the capacity to conform his conduct to the law.

In crafting a model outpatient commitment rule, we need not be hamstrung by New York law. Given the interest in public safety, limiting outpatient commitment to persons who are unable to appreciate the wrongfulness of their conduct would be too narrow. Consider the following rule combining Kendra's Law with the Model Penal Code:

ii. MODEL RULE: HARM TO OTHERS

- (a) A person who is competent to refuse treatment may be ordered to participate in an outpatient treatment program if, in view of his history or current behavior, he is likely to harm others as defined in section (b) of this article; and

³⁰² *Id.* at 170.

³⁰³ *Id.*

³⁰⁴ See ROBINSON, *supra*, note 156, at 369.

³⁰⁵ N.Y. PENAL LAW. §40.15 (McKinney 1984).

- (1) as a result of mental illness, he is unlikely to appreciate the wrongfulness of his conduct; or
 - (2) as a result of mental illness, he lacks the capacity to conform his conduct to the requirements of the law.
- (b) As used in this article the words “likely to harm” shall mean a substantial risk of serious physical harm as manifested by homicidal or other violent behavior.

1. COGNITIVE IMPAIRMENT

Under part (a)(1) of the proposed rule, a person who is competent to refuse treatment may be ordered to participate in outpatient treatment if, in view of his history or current behavior, he is likely to harm others, and as a result of a mental illness, he is unlikely to appreciate the wrongfulness of his conduct. Following the Model Penal Code we can say that a person may be unlikely to appreciate the wrongfulness of his conduct if, in the past, he has failed to apprehend material circumstances as a result of a mental illness, or failed to apprehend the significance of his conduct in some deeper sense. Suppose the fight that landed Gary in the hospital was not an “accident.” Instead, Gary pushed his mother to the ground based on a delusional belief that his family was plotting against him and, indeed, trying to kill him. During an outpatient commitment hearing, Gary’s sister testifies that her brother’s delusional beliefs about their family are longstanding and all-encompassing. On several occasions Gary has choked her and thrown her to the ground. During the worst incident, he held a knife to her throat. On the stand his sister sobbed: “When I asked him, Gary, why?” he said “You’re the devil. You came here to hurt me. Didn’t you?”

In its jurisprudence on preventive detention, mental illness and violence, the Supreme Court has often said: “[i]n our society, liberty is the norm.”³⁰⁶ However that liberty rests on certain fundamental presuppositions—foremost among them that, for the most part, our rational faculties

³⁰⁶ *Foucha v. Louisiana*, 504 U.S. 71, 85 (1992); *See also* *U.S. v. Salerno*, 481 U.S. 739, 755 (1987).

are intact. A person who believes that his sister is the devil is no longer competent to answer to the retributive functions of the criminal law. If Gary were to harm his sister, he would likely prevail on the cognitive arm of an insanity defense. However, the same cognitive impairments that exempt him from criminal punishment also identify him as an appropriate candidate for outpatient civil commitment. The more difficult question is this—what constitutes clear and convincing evidence that, as a result of a mental illness, a person is unlikely to appreciate the wrongfulness of his conduct? By definition, insanity defenses are necessarily backward looking and driven by conduct that has already taken place. Although risk assessments are necessarily fraught, as I mentioned above, a past history of violence is one of the best predictors of violence. The fact that Gary has a long history of violent assault connected to his delusional beliefs, suggests that without supervised medical treatment, he is likely to engage in similarly assaultive behavior.

2. VOLITIONAL IMPAIRMENT

Alternatively, under part (a)(2) of the proposed rule, a person who is competent to refuse treatment may be ordered to participate in outpatient treatment if he is likely to harm others, and as a result of a mental illness, he lacks the capacity to conform his conduct to the law. Consistent with the Model Penal Code formulation, what is required here is not that the person manifests a total inability to conform his conduct to the law, but only that his impairment is not insubstantial.³⁰⁷ Consider the following statement from Andrew Goldstein. When questioned by the police, Goldstein attributed his actions to an “overwhelming urge.”

I walked to the far end of the platform.... As I'm walking I felt a sensation like something was entering me like a ghost or a spirit or something like that. While I was walking it fell out of me. When I have the sensation that something is entering me, I get the urge to push, shove or sidekick. As the train was coming—it—the

³⁰⁷ Model Penal Code § 4.01 (1962).

feeling disappeared and came back several times....As I was standing on the platform, there was a woman standing waiting for the train. She was facing the incoming train and I was standing behind her. I got the urge to push, kick or punch....I feel like an aura, or a sensation like you're losing control of your motor systems. And then, you lose control of your senses and everything. And then you feel like something's entering you. Like you're being inhabited. I don't know. But—and then, it's like an overwhelming urge to strike out or push or punch...³⁰⁸

Stephen Morse has long argued that courts should reject the notion of an “uncontrollable urge” or any other purported loss of control as a justifiable predicate for civil commitment.³⁰⁹ Along with Robert Schopp, Morse starts from the premise that civil commitment amounts to a massive curtailment of liberty, one that can only be justified by limiting its use to people who are not morally responsible for their conduct. On the other hand, Morse thinks that only a defect in the capacity for rationality can work as a coherent non-responsibility criterion.

Without canvassing all of his arguments, below I want to challenge some of the more important ones, and in doing so suggest that we have reason to reconsider the use of a volitional impairment standard for outpatient civil commitment. Morse rests his arguments on a thin conception of moral responsibility. Morse takes the capacity for rationality to be the defining—and indeed the singular—feature of moral responsibility. But why should that be the case? In various places, Morse writes that our capacity for reason distinguishes human beings from the rest of the natural world.³¹⁰ Moreover, it is our capacity for rationality that explains why, as a general matter, our society does not confine for dangerousness alone, but instead treats human actors as moral agents who are capable of evaluating their conduct and responding to the law's commands. Yet such a narrow conception of moral responsibility seems strangely lacking.

³⁰⁸ EWING, *INSANITY, MURDER, MADNESS AND THE LAW*, *supra* note 152 at 116.

³⁰⁹ Stephen Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54 (1982); Stephen Morse, *Culpability and Control*, 142 U. PA. L. REV. 1587 (1994).

³¹⁰ Stephen Morse, *Uncontrollable Urges and Irrational People*, 88 VA. L. REV. 1025, 1066 (2002).

Suppose you invite me to a dinner party. Reluctantly, I accept. As dinner drags on, I twitch, I grimace and I jerk, as I wage a silent battle against the ticks and pops of Tourette's Syndrome. I say to myself: "I know I'm a good person. I know I'm a good person. I won't mention your husband's beer belly," but then, before I know it, out it slips: "beer belly! Beer belly! Beer belly! BEER BELLY!" In my horror I knock over a bottle of wine and stain your new dress. I fully understand that I have done something wrong by offending my friend's husband, but I couldn't help it. Morse takes the position that a mentally abnormal cause is merely a cause. "Whether a predisposing factor is produced by a mental disorder or by some other 'normal' or 'abnormal' cause makes no difference to whether the agent is responsible. A cause is just a cause, and causation per se is not an excuse."³¹¹ It may be that Morse has conflated the fact that an action is fully attributable to an agent with moral responsibility.³¹² The disruption caused by offending your husband, knocking over a bottle of wine and staining your new dress is fully attributable to me, but my blameworthiness is diminished to the extent that my outburst was caused by a neurological condition that is beyond my control.

Morse goes on to argue that control impairments are better understood as defects in the capacity for rationality. There is certainly a sense in which Goldstein's urge to "push, shove or sidekick," stems from a mental abnormality that we can understand, roughly, as a defect in rationality. On the other hand, the jurors who convicted him of second degree murder didn't think so. In *People v. Andrew Goldstein*, Andrew Goldstein pled not guilty by reason of insanity.³¹³ At trial

³¹¹ *Id.* at 1040.

³¹² See T.M. Scanlon, RESPONSIBILITY in WHAT WE OWE TO EACH OTHER (1998) (distinguishing moral responsibility from attributability).

³¹³ *People v. Goldstein*, No. 527/99 (N.Y. Sup. Ct. 1999).

prosecutors established that Goldstein knew that what he was doing was wrong and Goldstein conceded as much:

Prosecutor: Well, did you expect that she would go off the platform?

Goldstein: No. No. No. No. I would never push anybody off the tracks.

Prosecutor: Because you know it's wrong.

Goldstein: Yeah.³¹⁴

Even if Morse is right, and defenses based on a loss of control really are better understood as defects in the capacity for rationality, juries are unlikely to appreciate that subtlety. Instead jurors are more likely to understand their duty as applying the letter of the law, which means not reading a control defense into an insanity defense without clear textual support. In New York, the absence of a volitional impairment standard has clear implications for the insanity defense; as a result, Andrew Goldstein was found guilty, and indeed blameworthy, for the death of Kendra Webdale. However, the absence of volitional element would also have implications for an outpatient commitment statute. Without it, states would not have the power to reach someone like Andrew Goldstein.

A further objection to the control impairment argument concerns the degree to which a person must lack the capacity to conform his conduct to the requirements of law, and whether we can reliably distinguish those who unable to conform their conduct to the law from those who are merely unwilling to order their conduct within the law.³¹⁵ Volitional impairment arguments fell out of favor in the early 1980s when John Hinckley attempted to assassinate President Regan.³¹⁶

³¹⁴ Brief for Defendant-Appellant, *People v. Andrew Goldstein* (N.Y.S. Appellate Division, First Department, April 29, 2004) 26.

³¹⁵ See, e.g., *United States v. Moore*, 486 F.2d 1139 (D.C. Cir. 1973)(Mackinnon J., concurring)(“In my view the most impractical aspect of the ‘lack of substantial capacity to conform their conduct’ test is that in applying such test it would be practically impossible to separate those who lacked substantial capacity to conform their conduct to the law from those who possessed such capacity but who merely refused to conform their conduct.”).

³¹⁶ See HENRY J. STEADMAN ET AL., *BEFORE AND AFTER HINCKLEY EVALUATING THE INSANITY DEFENSE* 1-3 (1993).

Hinckley was found not guilty by reason of insanity owing in part to testimony that he was delusional and unable to control his behavior. In the aftermath of the Hinckley trial, the American Psychiatric Association advocated abolishing the volitional impairment test, on the ground that psychiatrists were unable to provide reliable testimony on self-control.³¹⁷ Others noted the absence of an objective methodology for determining volitional impairment.³¹⁸

What should we make of these claims? In *Crane* Justice Breyer conceded that the Court did not give the term “lack of control” a precise meaning, nor could it.³¹⁹ In cases where the defendant’s ability to control his or her behavior is at issue, “inability to control,” will not be demonstrable with mathematical precision.”³²⁰ On the other hand the Federal Bureau of Prisons (BOP) has developed a set of guidelines for experts to use when determining whether a sex offender has “serious difficulty” controlling his or her behavior.³²¹ Under the BOP guidelines relevant evidence might include—a risk assessment placing the defendant in a high risk category; offending while under supervision; engaging in offenses when likely to get caught; statements of intent to reoffend; an admission of difficulty controlling behavior; or general self-regulation problems in social settings. Similarly, in outpatient commitment cases, courts might consider evidence leading to a prior hospitalization. For example, Andrew Goldstein’s psychiatric record documents several

³¹⁷ Insanity Defense Work Group, *American Psychiatric Association Statement on the Insanity Defense*, 140 AM. J. PSYCHIATRY 681, 685 (1983)(adding “[t]he line between an irresistible impulse and an impulse not resisted is probably no sharper than that between twilight and dusk”).

³¹⁸ Richard J. Bonnie, *Morality, Equality, and Expertise: Renegotiating the Relationship between Psychiatry and the Criminal law*, BULL. AM. ACAD. OF PSYCHIATRY & L. 12 (1984).

³¹⁹ *Kansas v. Crane*, 534 U.S. 407 (2002).

³²⁰ *Id.*

³²¹ 73 Fed. Reg. 70, 278 (Nov. 20 2008)(to be codified at 20 C.F.R pt 549.95).

instances in which Goldstein swung or punched at others without provocation. And on more than one occasion before the death of Webdale, Goldstein complained of hearing voices and being unable to control his arms.³²²

CONCLUSION

When our primary concern is one of self-regarding harm, I have argued that a court order to participate in outpatient treatment requires a finding of incompetence. In its current form, Kendra's Law does not require a judicial finding of incompetence and as a result, Kendra's Law is needlessly overbroad. If, however, we are concerned about harm to others, a court order to participate in outpatient treatment may be appropriate for people with mental illnesses who are unlikely to appreciate the wrongfulness of their conduct, or otherwise unable to conform their conduct to the requirements of the law. By not limiting assisted outpatient treatment orders to people with mental illnesses who are unlikely to appreciate the wrongfulness of their conduct or unable to control their behavior, Kendra's Law intrudes on the purview of the criminal justice system, a result clearly disfavored in *Hendricks* and *Crane*.

An approach of this kind is likely to raise a few objections. The first is that my emphasis on competence to refuse treatment stems from an overvaluation of autonomy. Others will argue that I have misunderstood, or at least too narrowly understood, what it means to respect autonomy. We can respect autonomy, not only by respecting competent treatment decisions, but also by intervening to preserve autonomy. However, arguments along these lines provide a dangerous justification for outpatient commitment and are ripe for potential abuse.

Second, an approach that restricts compulsory mental health treatment to those who are incompetent to make treatment decisions, or otherwise incompetent to bear the burdens of the criminal law, would place many people with serious and persistent mental illnesses beyond the scope

³²² IN THE MATTER OF DAVID DIX, *supra* note 36.

of court ordered treatment. However, even the best studies on outpatient commitment have shown that a court order to participate in treatment only adds value when combined with a high level of outpatient services, on the order of three or more visits per month.³²³ On the ground, providers have also indicated that outpatient commitment works primarily by placing an order on the provider to render services.³²⁴ Other studies have shown that there may be effective alternatives to outpatient commitment including assertive community treatment, intensive case management and supported housing.³²⁵ There is a place for Kendra's Law but it requires adequate resources to ensure that effective services are available and further amendment to protect the liberty interests of the mentally ill.

³²³ Jeffrey Swanson et al., *Involuntary Outpatient Commitment and Reduction of Violent Behavior in Persons with Severe Mental Illness*, 176 BRIT. J. PSYCH. 324 (2000).

³²⁴ M. Susan Ridgely et al. *The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States*. RAND Institute of Civil Justice available at <http://www.rand.org> (last visited Jan. 5, 2013).

³²⁵ John Monahan, *Mandated Community Treatment: Beyond Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 1198 (2001).

CHAPTER 3

PUBLIC ASSISTANCE, DRUG TESTING AND THE LAW: A PUBLIC HEALTH PERSPECTIVE

In 2011 three dozen states considered bills that require applicants to pass a drug test before they qualify for income assistance through the Temporary Assistance to Needy Families Program (TANF).³²⁶ Several state legislators have also proposed bills that would require applicants to pass a drug test in order to qualify for food stamps, public housing, home heating assistance and unemployment benefits.³²⁷ To date, eight states condition public assistance benefits on passing a drug test, including—Arizona, Florida, Georgia, Michigan, Missouri, Oklahoma, Tennessee and Utah.³²⁸ Proposals to condition public assistance on passing a drug test have also appeared in Congress. At the federal level, the Middle Class Tax Relief and Job Creation Act of 2012 authorizes states to condition unemployment benefits on passing a drug test and to deny unemployment benefits to anyone who fails a drug test.³²⁹ The Drug-Free Families Act, presently stalled in the

³²⁶ A.G. Sulzberger, *States Adding Drug Test as Hurdle for Welfare*, N.Y. TIMES, October 10, 2011, at A1; *See also* National Conference of State Legislatures, DRUG TESTING AND PUBLIC ASSISTANCE, <http://www.ncsl.org/issues-research/human-services/drug-testing-and-public-assistance.aspx> (last visited Jun. 21, 2012) (for a comprehensive survey of drug testing legislation in the states).

³²⁷ *See e.g.* H.B. 208, 11th Reg. Sess. (Ky. 2011) (establishing a substance screening program for adults who receive monetary public assistance, food stamps, or state medical assistance); S. 69, 129th Reg. Sess. (Oh. 2011) (establishing a drug testing requirement for adults who apply for need-based programs that provide cash assistance, medical assistance, housing assistance, food assistance, or energy assistance); H.B. 1174, 87th Gen. Assemb., Reg. Sess. (Sd. 2012) (directing the Department of Social Services to screen and test any adult recipient who is otherwise eligible for TANF or food stamps).

³²⁸ ARIZ. REV. STAT. § 46-294 (2011); FLA. STAT. ANN. § 414.0652 (2012); S.B. 292, 151st Gen. Assemb., Reg. Sess. (Ga. 2012) (to be codified at GA. CODE ANN. § 49-4-3.1); MICH. STAT. ANN. § 400.57e(e) (2012); MO. REV. STAT. § 208.027 (2012); H.B. 2388, 53rd Leg., 2nd Reg. Sess. (Ok. 2012) (to be codified at OKLA. STAT. § 230.52); S.B. 2580, 107th Gen. Assemb., Reg. Sess. (Tn. 2012) (to be codified at TENN. CODE ANN. § 71-5-2); H.B. 155, 59th Leg. Sess. (Ut. 2012) (to be codified at UTAH CODE ANN. § 35A-3-304.5).

³²⁹ H.R. 3630, 112th Cong. § 2127 (2012).

House and Senate, would require all 50 states to deny TANF assistance to anyone who tests positive for illegal drugs and to anyone convicted of a drug-related crime.³³⁰

Although most states require a reasonable suspicion of illegal drug use before conducting a drug test, Florida and Georgia do not. Both states require a drug test for all TANF applicants irrespective of drug history or current suspicion of illegal drug use. In Florida, Governor Scott has emphasized the unfairness of asking taxpayers to subsidize illegal drug use. In a statement to the press, Scott put it this way: “While there are certainly legitimate needs for public assistance, it is unfair for Florida taxpayers to subsidize drug addiction.”³³¹ He continued: “This new law will encourage personal accountability and will help to prevent the misuse of tax dollars.”³³² In Missouri, Representative Ellen Brandom, echoed Scott’s concerns: “We should discourage drug use and not reward it.” She continued: “Working people today work very hard to make ends meet, and it just doesn’t seem fair to them that their tax dollars go to support illegal things.”³³³

While support for drug testing has largely focused on the unfairness of asking taxpayers to subsidize illegal drug use, supporters have also invoked other government interests in drug testing, including a state interest in providing an incentive for people to get off drugs. In Georgia, the State Legislature has said that an important purpose of the new law is to reduce the danger that children will be exposed to drugs in the home.³³⁴ Other states including Alabama, Michigan and Oklahoma

³³⁰ S. 83, 112th Cong. (2011).

³³¹ Press Release, *Governor Scott Fulfills Campaign Promise to Require Drug Require Drug Screening for Welfare Recipients* (June 3, 2011). <http://www.flgov.com/2011/06/03/governor-scott-fulfills-campaign-promise-to-require-drug-screening-for-welfare-recipients/> (last visited Jun. 21, 2012).

³³² *Id.*

³³³ Sulzberger, *supra* note 1, at A1.

³³⁴ S.B. 292, 151th Gen. Assemb., Reg Sess. (Ga. 2012) (to be codified at GA. CODE ANN. § 49-4-3.1).

have asserted a state interest in preventing drug-related child abuse, as well as a state interest in identifying TANF recipients for whom substance abuse might present a barrier to employment.³³⁵ In addition, both Florida and Georgia have asserted a state interest in not funding the public health and crime risks associated with drug use.³³⁶ In response, critics maintain that drug tests are needlessly intrusive and unfairly single out the poor for a drug test.³³⁷

The Fourth Amendment prohibits unreasonable searches and seizures, and the Supreme Court has long held that a drug test constitutes a search within the meaning of the Fourth Amendment. In the legal debate surrounding drug testing and public assistance, the question is whether drug tests are unreasonable as a matter of constitutional law. Under the special needs doctrine, the Supreme Court has said that a drug test may be reasonable without an individualized suspicion of drug use when governments confront “special needs beyond the normal need for law enforcement.”³³⁸ In *Chandler v. Miller*, the Supreme Court articulated a strong public safety rationale for the special needs doctrine. In an opinion by Justice Ginsburg, the Supreme Court held that “where the risk to public safety is substantial and real,” suspicionless searches may be reasonable, but where “public safety is not genuinely in jeopardy, the Fourth Amendment precludes the

³³⁵ Brief of the States of Alabama, Kansas Michigan and Oklahoma As Amicus Curiae In Support of Appellant and Reversal, *Lebron v. Wilkins*, 2012 WL 367094, at*17 (11th Cir. Jan. 25, 2012) (No. 11-15258) (opinion forthcoming); *Marchwinski v. Howard*, 309 F.3d 330, 333 (6th Cir. 2002).

³³⁶ *Supra* note 328.

³³⁷ See e.g. Press release, *Gov. Scott's Targeting of Welfare Recipients for Drug Screening Misguided*. (May 31, 2011) <http://www.alceehastings.house.gov/index.php?> (last visited Jun. 21, 2012) (Representative Corrine Brown arguing that drug tests for welfare recipients amount to “strip searching our state’s most vulnerable residents merely because they rely on the government for financial support during these difficult economic times.”).

³³⁸ *New Jersey v. T.L.O.*, 469 U.S. 325, 351 (1985); *Skinner v. Railway Labor Executives*, 489 U.S. 602, 618 (1989).

suspicionless search no matter how conveniently arranged.”³³⁹ Yet, subsequent Supreme Court decisions have stretched to construe the government interest in a suspicionless search as falling within the scope of the public safety exception, while also suggesting that the special needs doctrine might encompass government interests beyond a government interest in public safety.³⁴⁰

Following *Chandler*, this paper will argue that absent a genuine threat to public health or public safety, proposals to condition public assistance on passing a drug test without individualized suspicion of drug use are unreasonable under the Fourth Amendment. Part I will provide a brief overview of TANF and state efforts to condition public assistance on passing a drug test. Part II will discuss the evolution of the special needs doctrine. Part III will present a public health approach to the special needs doctrine. As a discipline, public health concerns the health and longevity of populations.³⁴¹ Importantly, public health values empirical analysis, often based on epidemiological data, rather than an examination of legal precedent.³⁴² To that end, Part III will present a framework for risk assessment to guide a special needs analysis under *Chandler*. Part III will also argue that even if the Supreme Court were to recognize special needs beyond a genuine threat to public health or public safety, policies that result in withholding public assistance benefits from people who abuse illegal drugs are unlikely to accomplish many of the states’ objectives and are instead likely to make many social problems much worse.

³³⁹ *Chandler v. Miller*, 520 U.S. 305, 323 (1997).

³⁴⁰ See discussion *infra* pp. 12-13.

³⁴¹ LAWRENCE GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* 16 (2008).

³⁴² Wendy Parmet, *Beyond Privacy: A Population Approach to Reproductive Rights in RECONSIDERING LAW AND POLICY DEBATES: A PUBLIC HEALTH PERSPECTIVE* 15, 27 (John Culhane ed., 2011).

I. TANF: TEMPORARY ASSISTANCE TO NEEDY FAMILIES

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PWRORA) ended the Aid to Families with Dependent Children Program (AFDC) and replaced it with TANF (Temporary Assistance to Needy Families).³⁴³ The overarching purpose of TANF is to move recipients of public assistance from welfare to work. With few exceptions, PWRORA requires TANF recipients to find at least part-time work within two years.³⁴⁴ PWRORA mandates at least 20 hours of work per week for parents with children over age 6, and it impose a lifetime limit of no more than sixty months on the receipt of federal aid, with a state option for a shorter lifetime limit.³⁴⁵ States receive TANF block grants and are required to use those funds in a manner reasonably calculated to accomplish any one or more of the four TANF program goals: (i) assisting needy families so that children can be cared for in their homes; (ii) reducing the dependency of needy parents by promoting job preparation, work, and marriage; (iii) preventing out-of-wedlock pregnancies; and, (iv) encouraging the maintenance and formation of two-parent families.³⁴⁶

Federal and state laws limit TANF to low income families in which the household includes a minor child or a pregnant woman.³⁴⁷ With few exceptions, qualified households must demonstrate that their total income is no more than 200% of the federal poverty level (\$37,060 for a family of

³⁴³ 42 U.S.C. §§ 601-619 (2006).

³⁴⁴ *Id.* at § 602(a)(1)(ii) (2006).

³⁴⁵ *Id.* at § 607(c)(2)(B), §608(a)(7) (2006).

³⁴⁶ *Id.* at § 601(a) (2006).

³⁴⁷ *Id.* at § 608(a)(1) (2006).

three in 2011 and \$44,700 for a family of four).³⁴⁸ Although income assistance is one of the primary benefits of participation in TANF, the average cash benefit varies widely from state to state, ranging from \$750 for a single parent of three in New York to \$170 in Mississippi. In Florida, the average benefit was \$303 in 2011 and \$280 for a family of three in Georgia.³⁴⁹

A. DRUG TESTING AND THE STATES

i. REASONABLE SUSPICION

PWRORA authorizes, but does not require, drug testing as a condition of assistance through TANF.³⁵⁰ In the handful of states that have enacted a drug testing requirement, most require “reasonable cause” or “reasonable suspicion” of drug use before conducting a drug test.³⁵¹ In Arizona, TANF applicants are asked to complete a recent drug use questionnaire.³⁵² Applicants who admit that they have used drugs are required to pass a urine test before receiving benefits. Those who fail the urine test are TANF-ineligible for one year. Not surprisingly, very few applicants tend to disclose drug use. Since 2009, when drug testing began in Arizona, only 16 applicants out of 64,000 have admitted drug use and 931 applicants failed to submit the form.³⁵³

³⁴⁸ *Id.* at § 604(3) (2006); 70 FED. REG. 3485, 3637-38 (2011).

³⁴⁹ IFE FINCH & LIZ SCHOTT, CENTER ON BUDGET AND POLICY PRIORITIES, TANF BENEFITS FELL FURTHER IN 2011 AND ARE WORTH MUCH LESS THAN IN 1996 IN MOST STATES, <http://www.cbpp.org/cms/?fa=view&id=3625> (last visited Jun. 21, 2012).

³⁵⁰ 21 U.S.C. § 862b (2006) provides: “Notwithstanding any other provision of law, States shall not be prohibited by the Federal Government from testing welfare recipients for use of controlled substances nor from sanctioning welfare recipients who test positive for use of controlled substances.”

³⁵¹ *See e.g.* MO. REV. STAT. § 208.027.1 (2012).

³⁵² A.G. Sulzberger, *supra* note 1, A1.

³⁵³ *Id.*

Given the obvious limitations of screening by self-report, most states rely on case managers and substance abuse counselors to recognize the signs of drug use. In Missouri, the Department of Social Services screens TANF applicants and recipients for drug use and conducts a test when it has reasonable cause to suspect drug use based on the screen.³⁵⁴ Any applicant or recipient who tests positive for drugs is TANF-ineligible for a period of three years, unless he or she successfully completes a treatment program.³⁵⁵ In Missouri, TANF applicants who test positive for drugs have the option to retain their benefits on the condition that they enroll in a substance abuse treatment program for six months and do not test positive for drugs, while participating in the program. During that time, the Department of Social Services retains the right to conduct drug tests at random and for cause. If the person tests positive for drugs a second time, he or she is TANF-ineligible for three years.³⁵⁶

ii. SUSPICIONLESS DRUG TESTING

In May 2011 the Florida State Legislature passed HB 353, a law that requires all new TANF applicants to pass a drug test before they qualify for benefits.³⁵⁷ Under HB 353, applicants who test positive for drugs are ineligible for TANF-funded cash assistance for one year following the date of a positive drug test.³⁵⁸ Applicants who test positive for drugs would remain eligible for other TANF programs including food stamps and child care. In Florida, TANF applicants bear the initial costs

³⁵⁴ MO. REV. STAT. § 208.027.1 (2012).

³⁵⁵ *Id.*

³⁵⁶ *Id.*

³⁵⁷ F.L.A. STAT. §414.0652 (1996).

³⁵⁸ *Id.* § (1)(b).

of their drug tests, which usually range from \$25 to \$45.³⁵⁹ Applicants who test negative for drugs receive a reimbursement through their initial TANF benefit. If a person tests positive for drugs, he or she can reapply for TANF benefits upon successful completion of a treatment program offered by a qualified provider.³⁶⁰ An applicant who tests positive for drugs a second time would be TANF-ineligible for three years.³⁶¹ If a parent tests positive for drugs, he or she can appoint a payee to receive benefits on behalf of the child.³⁶²

Since Florida enacted HB 353 in May, several others states have passed suspicionless drug testing requirements including Georgia, Tennessee and Oklahoma. In April 2012, the Georgia State Legislature adopted the Social Responsibility and Accountability Act.³⁶³ According to the Legislature, the purpose of the statute is to ensure that TANF funds are used for their intended purposes, to protect children from drug use in the home and to assist adults who are addicted to drugs.³⁶⁴ Like HB 353, the Social Responsibility and Accountability Act directs the Department of Human Services to administer a drug test to every applicant for TANF assistance, and to deem any person who fails a drug test ineligible for benefits.³⁶⁵ If an applicant tests positive for drugs, he or she would be TANF ineligible for one month, and for longer intervals following every subsequent

³⁵⁹ Brief for Plaintiff at 6, *Lebron v. Wilkins*, 820 F. Supp. 2d 1273 (M.D. Fla. 2011) (No. 6:11-cv-01473-Orl-35DAB).

³⁶⁰ F.L.A. STAT. §414.0652 (2)(b) (2012).

³⁶¹ *Id.* (2)(h).

³⁶² *Id.* (3)(b).

³⁶³ S.B. 292, 151th Gen. Assemb., Reg Sess. (Ga. 2012) *supra* note 334.

³⁶⁴ *Id.*

³⁶⁵ *Id.* at § 49-4-3.1(b).

positive drug test. Similarly, Tennessee and Oklahoma require a drug test when anyone applies for TANF.³⁶⁶

II. THE FOURTH AMENDMENT

The Supreme Court has long held that a drug test constitutes a search within the meaning of the Fourth Amendment.³⁶⁷ But when does a search become unreasonable? The Fourth Amendment provides:

The right of the people to be free from unreasonable searches and seizures shall not be violated, and no Warrants shall issue, but upon probable cause, supported by Oath or affirmation, and particularly describing the place to be searched, and the persons or things to be seized.³⁶⁸

One school of thought maintains that searches and seizures are *per se* unreasonable unless supported by a warrant and probable cause, or one of a few limited exceptions to the warrant requirement. For adherents to the warrant preference rule, individualized suspicion is a bedrock requirement of reasonableness.³⁶⁹ An alternative view maintains that the Warrant Clause and Reasonableness Clause are independent, and the Fourth Amendment contains “no irreducible requirement” of individualized suspicion.³⁷⁰ For proponents of the latter view, the ultimate measure of

³⁶⁶ *Id.* at § 49-4-3.1(f).

³⁶⁷ *Skinner v. Railway Labor Executives*, 489 U.S. 602 (1989).

³⁶⁸ U.S. CONST. amend. IV.

³⁶⁹ Thomas K. Clancy, *The Role of Individualized Suspicion in Assessing the Reasonableness of Searches and Seizures*, 25 U. MEM. L. REV. 483, 488 (1995).

³⁷⁰ *Vernonia School Dist. 47J v. Acton* 515 U.S. 646, 653 (1995).

constitutionality under the Fourth Amendment is reasonableness, and the reasonableness of a government search depends on the totality of the circumstances.³⁷¹

For many years, a long line of Fourth Amendment cases held that a reasonable government search requires a warrant, probable cause or an exception to the warrant requirement.³⁷² And yet, as Justice Scalia has observed, on the Supreme Court, Fourth Amendment jurisprudence has “lurched back and forth between imposing a categorical warrant requirement and looking to reasonableness alone.”³⁷³ To the regret of many Fourth Amendment scholars, the Court has begun to jettison the categorical protection of warrant requirement in favor of a general reasonableness requirement.³⁷⁴ For now, however, the rule continues to be that a reasonable government search requires a warrant or an exception to the warrant requirement. Since the late 1980s, the Supreme Court has addressed government drug testing policies under the special needs exception to the warrant requirement. Part II.A. discusses the evolution of the special needs doctrine.

A. THE SPECIAL NEEDS DOCTRINE

The Supreme Court departed from the warrant and probable cause requirements for the first time in *Camara v. Municipal Court of San Francisco*.³⁷⁵ In doing so, the Court began to lay the groundwork for the special needs doctrine. *Camara* began when housing inspectors entered Roland Camara’s apartment building to conduct a routine inspection of the building for violations of the

³⁷¹ See e.g., *New Jersey v. T.L.O.*, 469 U.S. 325, 337 (1985); *Vernonia Sch. Dist.*, 515 U.S. at 652.

³⁷² THOMAS MCINNIS, *THE EVOLUTION OF THE FOURTH AMENDMENT* 124 (2009).

³⁷³ *California v. Acevedo*, 500 U.S. 565, 582 (1991).

³⁷⁴ See e.g., Tracey Maclin, *The Central Meaning of the Fourth Amendment*, 35 WM. & MARY L. REV. 197 (1993).

³⁷⁵ 387 U.S. 523 (1967).

city housing code. When inspectors asked Camara for permission to enter his apartment, Camara refused on the ground that the inspectors lacked a search warrant, and without probable cause to believe that a violation of the housing code existed, Camara argued that the inspection would violate his rights under the Fourth Amendment.³⁷⁶

In an opinion by Justice White, the Supreme Court held that while housing safety inspections constitute a significant intrusion on Fourth Amendment interests, requiring housing inspectors to obtain a warrant would “frustrate the governmental purpose behind the search.”³⁷⁷ Nor were suspicionless inspections unreasonable for want of probable cause to believe that a particular building contained violations of the housing code. Traditional probable cause would have required facts sufficient to warrant a person of reasonable caution in the belief that a crime either had been or was being committed. So construed, probable cause would have precluded suspicionless building inspections. To Justice White and members of the majority, the problem could be resolved by redefining probable cause in terms of reasonableness. “In determining whether a particular inspection is reasonable—and thus in determining whether there is probable cause to issue a warrant for that inspection—the need for the inspection must be weighed in terms of the reasonable goals of code enforcement.”³⁷⁸ On one side of the balance were the interests of the government in identifying hazardous conditions that might present a danger to the public. On the other side of the balance were the individual interests in privacy. To the majority, suspicionless housing inspections involved a “relatively limited invasion of the urban citizen’s privacy.”³⁷⁹ Housing

³⁷⁶ *Id.* at 527.

³⁷⁷ *Id.* at 533.

³⁷⁸ *Id.* at 535.

³⁷⁹ *Id.* at 537.

inspections were not searches of the person, nor were they geared toward the discovery of criminal evidence.³⁸⁰

Throughout *Camara*, the Court asserted that the government interest in public health and public safety justified a departure from the warrant requirement and traditional probable cause:

Time and experience have forcefully taught that the power to inspect dwelling places...is of indispensable importance to the maintenance of community health; a power that would be greatly hobbled by the blanket requirement of the safeguards necessary for a search of evidence of criminal acts. The need for preventive action is great, and city after city has seen this need and granted the power of inspection to its health officials....³⁸¹

The Supreme Court invoked a similar argument several years later in *New Jersey v. T.L.O.* *T.L.O.* began when a high school teacher discovered two girls smoking in a lavatory.³⁸² The teacher took both girls, one of whom was T.L.O., to the principal's office. When T.L.O. denied that she had been smoking, and claimed that she did not smoke at all, the vice principal demanded to see her purse. Upon opening her purse, he noticed a pack of rolling papers, and upon further inspection, he observed further evidence of drug use: a small amount of marijuana, a pipe, empty plastic bags, several one-dollar bills, and an index card listing the names of students who owed T.L.O. money.³⁸³ The vice principal turned the evidence over to the police and T.L.O. confessed that she had been selling drugs at school. T.L.O. moved to suppress the evidence on the ground that the vice principal

³⁸⁰ *Id.*

³⁸¹ *Id.*

³⁸² 469 U.S. 325 (1985).

³⁸³ *Id.* at 347.

proceeded without probable cause, and the warrantless search of her purse violated the Fourth Amendment.³⁸⁴

In an opinion by Justice White, the Supreme Court held that the search of T.L.O.'s purse was not unreasonable. Once again Justice White argued that the touchstone of the Fourth Amendment is reasonableness, and whether a search is reasonable depends on both the context in which it takes place and balancing the interests at stake.³⁸⁵ Striking the balance in favor of schools, the Court concluded that a warrant requirement would “frustrate” the school’s interest in maintaining swift discipline. Nor would a valid Fourth Amendment search require probable cause.³⁸⁶ The report that T.L.O. had been smoking in the lavatory was enough to provide the vice principal with a “reasonable suspicion” that her purse contained cigarettes, and thereby render the search of T.L.O.’s purse consistent with the Fourth Amendment.³⁸⁷ Citing *Terry v. Ohio*, Justice White suggested that a “reasonable suspicion” of wrongdoing is a lower standard than probable cause, but more than an inchoate suspicion or “hunch.”³⁸⁸ Instead, a reasonable suspicion of wrongdoing requires “specific and articulable facts.”³⁸⁹

Justice Blackmun wrote separately in concurrence to underscore that while the Court had recognized limited exceptions to the probable cause requirement, it had done so only when confronted with a “special need” for greater governmental flexibility:

³⁸⁴ *Id.* at 329.

³⁸⁵ *Id.* at 337.

³⁸⁶ *Id.* at 339.

³⁸⁷ *Id.* at 338.

³⁸⁸ *Id.* at 347.

³⁸⁹ *Terry v. Ohio*, 392 U.S. 1, 21 (1985).

Only in those exceptional circumstances in which special needs, beyond the normal need for law enforcement, make the warrant and probable cause requirement impracticable, is a court entitled to substitute its judgment for that of the Framers.³⁹⁰

According to Justice Blackmun, the Framers had already balanced the interests at stake and decided that a search is unreasonable unless supported by a warrant and probable cause. Only when the warrant and probable cause requirements are impracticable are courts permitted to substitute their judgment for that of the Framers. To Justice Blackmun, elementary and secondary schools presented a quintessential need for greater governmental flexibility—teachers cannot maintain discipline if they are required to obtain a warrant before searching a student, nor can we expect teachers to make quick on-the-spot decisions about probable cause.³⁹¹

Following *T.L.O.*, the Court invoked the special needs doctrine for the first time in *O'Connor v. Ortega*.³⁹² In *Ortega*, a plurality of Justices held that it was not unreasonable for a hospital investigative team to enter the office of a public employee and seize several items from his desk without a warrant and without probable cause. In an opinion by Justice O'Connor, the plurality held that “special needs, beyond the normal need for law enforcement” would make the warrant and probable cause requirements impracticable when government employers investigate office misconduct. Although public employees do not lose their Fourth Amendment rights merely because they work for the government instead of a private employer, “the operational realities of the workplace” can make some expectations of privacy unreasonable.³⁹³ Requiring employers to secure a warrant in order to search an employee’s office for evidence of workplace misconduct would be

³⁹⁰ *T.L.O.*, 469 U.S. at 351.

³⁹¹ *Id.* at 339.

³⁹² 480 U.S. 707 (1987).

³⁹³ *Id.* at 717.

unduly burdensome.³⁹⁴ Moreover, if employers were required to establish probable cause before conducting an investigation, the delays could result in “irreparable damage” to the public interest.³⁹⁵

In *Griffin v. Wisconsin*, the Supreme Court upheld a state statute that permitted probation officers to search the home of a probationer without a warrant, as long as the officers had “reasonable grounds” to believe that the search would reveal contraband.³⁹⁶ Based on a tip from a police detective, plainclothes police officers and probation officers searched Griffin’s apartment where they found a handgun that provided the basis for his conviction on a subsequent weapons offense. In an opinion by Justice Scalia, the Supreme Court held that states have a “special need” to supervise probationers and the officer’s tip provided reasonable grounds for the search. As it had in *Camara*, the Court also emphasized the government interest in public health and public safety. The purpose of the statute was to ensure that “probation serves as a period of genuine rehabilitation and that the community is not harmed by the probationer being at large.”³⁹⁷ Moreover, probation officers are employees of the State Department of Health and Human Services who were required to provide counseling with wellbeing of their “client” in mind.³⁹⁸ The Court also reiterated its unwillingness to impose a warrant or probable cause requirement if doing so would frustrate important governmental interests or otherwise pose a threat to public safety.³⁹⁹

³⁹⁴ *Id.* at 722.

³⁹⁵ *Id.* at 742.

³⁹⁶ 483 U.S. 866 (1987).

³⁹⁷ *Id.* at 875.

³⁹⁸ *Id.* at 876.

³⁹⁹ *Id.* at 879.

In *T.L.O.*, *Ortega*, and *Griffin*, the Supreme Court upheld searches of property based on a reasonable suspicion of wrongdoing. In *Skinner v. Railway Labor Executives*, and its companion case *National Treasury Employees Union v. Von Raab*, the Supreme Court turned its attention to drug tests without a suspicion of drug use. In *Skinner*, the Supreme Court upheld regulations promulgated by the Federal Railroad Administration that required drug and alcohol testing for railroad employees who were involved in a major train accident, without a warrant and without suspicion that a particular employee might have been intoxicated.⁴⁰⁰ The Supreme Court held that not unlike the government interest in maintaining discipline in schools or supervising probationers, the government interest in regulating the conduct of railroad employees constitutes a special need beyond the normal need for law enforcement.⁴⁰¹ The Federal Railroad Administration (FRA) was able to provide extensive evidence that workplace intoxication was a serious problem in the railroad industry.⁴⁰² The FRA was also able to provide evidence that railroads were only able to detect a small number of violations when they relied on supervisors to observe employees in the past.⁴⁰³

Nor were the federal regulations unreasonable for lack of individualized suspicion. Writing for the Court, Justice Kennedy underscored that while the Supreme Court has usually required some measure of individualized suspicion before conducting a search, “a showing of individualized suspicion is not a constitutional floor, below which a search must be presumed unreasonable.”⁴⁰⁴ He continued:

⁴⁰⁰ 489 U.S. 602 (1989).

⁴⁰¹ *Id.* at 620.

⁴⁰² *Id.* at 607.

⁴⁰³ *Id.* at 608.

⁴⁰⁴ *Id.* at 624.

In limited circumstances, where the privacy interests at stake are minimal, and where an important governmental interest furthered by the intrusion would be placed in jeopardy by a requirement of individualized suspicion, a search may be reasonable despite the absence of such suspicion.⁴⁰⁵

The Court concluded that even though urine tests constitute a search, the intrusions on privacy were limited. Federal regulations did not require employees to furnish samples under direct observation, and railroad employees have a diminished expectation of privacy by virtue of their participation in an industry that is heavily regulated to ensure safety.⁴⁰⁶

In *Von Raab*, the Supreme Court upheld federal regulations that required a drug test for all employees in the United States Customs Service who applied for a promotion to a position that involved the interdiction of illegal drugs, or to a position that required employees to carry a firearm, or handle classified materials.⁴⁰⁷ In contrast to the Federal Railroad Administration, however, the Customs Service was unable to provide any evidence that illegal drug use was a serious problem among its employees. Yet to describe the drug testing program as unreasonable given the lack of evidence regarding a drug problem was, for Justice Kennedy, to hold “an unduly narrow view of the context in which the Service’s testing program took place.”⁴⁰⁸ Instead the Court alluded to the national war on drugs: “The Customs Service is our Nation’s first line of defense against one of the greatest problems affecting the health and welfare of our population. We have adverted before to the veritable national crisis in law enforcement caused by smuggling of illicit narcotics.”⁴⁰⁹ To that

⁴⁰⁵ *Id.*

⁴⁰⁶ 1418.

⁴⁰⁷ 489 U.S. 656 (1989).

⁴⁰⁸ *Id.* at 673-74.

⁴⁰⁹ *Id.* at 668.

end, the Court characterized the government interest as “compelling.”⁴¹⁰ The Court also held that customs agents on the frontlines of drug interdiction have a diminished expectation of privacy.⁴¹¹ Given the “extraordinary safety and national security hazards” that would arise if the Customs Service were to promote illegal drug users to positions that required them to carry a firearm or interdict controlled substances, the drug testing policy was not unreasonable.⁴¹²

Several years later the Supreme Court revisited suspicionless drug testing in the context of public schools. In *Vernonia School District 47J v. Acton*, the Supreme Court upheld a policy that required student athletes to submit to random drug testing as a condition of participation in interscholastic athletics.⁴¹³ According to the trial court, the school district implemented the policy in response to a noticeable increase in drug use and disciplinary problems among students, particularly student athletes.⁴¹⁴ Based on testimony from teachers and school administrators, the trial court found that “a large segment of the student body, particularly those involved in interscholastic athletics, was in a state of rebellion” and “[d]isciplinary actions had reached ‘epidemic proportions.’”⁴¹⁵ Not only would drug use increase the risk of sports-related injury, but school administrators feared that in their small community on the edge of town, drug use by student athletes could create a “role model effect,” thereby fueling drug use among other students.⁴¹⁶

⁴¹⁰ *Id.* at 670.

⁴¹¹ *Id.* at 672.

⁴¹² *Id.* at 674.

⁴¹³ 515 U.S. 646 (1995).

⁴¹⁴ *Acton v. Vernonia Sch. Dist.*, 796 F. Supp. 1354, 1356 (D. Or. 1992).

⁴¹⁵ *Id.* at 1357.

The Supreme Court held that drug testing was not unreasonable under the circumstances, even without individualized suspicion of illegal drug use. The Court, per Justice Scalia, asserted that the Fourth Amendment does not impose an “irreducible requirement” of individualized suspicion.⁴¹⁷ Instead the ultimate measure of constitutionality under the Fourth Amendment is reasonableness.⁴¹⁸ Justice Scalia noted that in contrast to members of the general public, schoolchildren are required to submit to routine screenings, vaccinations, and physical exams; and therefore, children have a diminished expectation of privacy within the school environment.⁴¹⁹ Moreover, “[b]y choosing to ‘go out for the team’” student athletes “voluntarily subject themselves to a degree of regulation even higher than that imposed on students generally.”⁴²⁰ On the other hand, the Court characterized the government interest in deterring illegal drug use among schoolchildren as “important—indeed, perhaps compelling.”⁴²¹

In 1997, after an uninterrupted line of cases upholding searches under the special needs doctrine, the Supreme Court struck down a Georgia law that required candidates for public office to pass a drug test as a condition of placement on the state ballot in *Chandler v. Miller*.⁴²² In support of

⁴¹⁶ *Id.* at 1363.

⁴¹⁷ *Vernonia*, 515 U.S. at 653.

⁴¹⁸ *Id.* at 652.

⁴¹⁹ *Id.* at 656.

⁴²⁰ *Id.* at 657.

⁴²¹ *Id.* at 661.

⁴²² 520 U.S. 305 (1997).

the certification requirement, Georgia asserted a state interest in ensuring fitness for office.⁴²³ The government also argued that illegal drug use would undermine public confidence in elected officials, and compromise the ability of elected officials to discharge their public functions, particularly their ability to enforce anti-drug laws.⁴²⁴

However, in an 8-1 opinion, Justice Ginsburg held that Georgia's certification requirement did not fit within the "closely guarded category" of permissible suspicionless searches.⁴²⁵ Notably absent from the government's case was "any indication of a concrete danger demanding departure from the Fourth Amendment's main rule."⁴²⁶ While evidence of a concrete danger was not indispensable given *Von Raab*, evidence of a genuine problem would at least "shore up" the assertion of a special need.⁴²⁷ "What is left" Justice Ginsburg wrote, "is the image the State seeks to project. By requiring candidates for public office to submit to a drug test, Georgia displays its commitment to the struggle against drug abuse."⁴²⁸ However, the state interest in setting an example is more "symbolic" than substantial within the meaning of the special needs doctrine.⁴²⁹ In *Chandler* the Court defined the term substantial as a government interest that is both "important enough to

⁴²³ *Id.* at 312.

⁴²⁴ *Id.* at 318.

⁴²⁵ *Id.* at 309.

⁴²⁶ *Id.* at 318-319.

⁴²⁷ *Id.* at 306.

⁴²⁸ *Id.* at 321.

⁴²⁹ *Id.* at 322.

override the individual interest in privacy” and “sufficiently vital to suppress the Fourth Amendment’s normal requirement of individualized suspicion.”⁴³⁰

The Court also indicated that a reasonable suspicionless search requires evidence of a genuine threat to public safety:

We reiterate too, that where the risk to public safety is substantial and real, blanket suspicionless searches calibrated to the risk may rank as “reasonable” – for example, searches now routine at airports....But where, as in this case, *public safety is not genuinely in jeopardy*, the Fourth Amendment precludes suspicionless searches no matter how conveniently arranged.⁴³¹

Five years later, the Supreme Court also struck down a state statute that authorized drug tests for maternity patients suspected of cocaine use without the patient’s consent and without a warrant in *Ferguson v. City of Charleston*.⁴³² Hospital administrators, police officers and local officials crafted the policy in response to a noticeable increase in cocaine use among patients who were receiving prenatal treatment.⁴³³ Patients who tested positive for cocaine were referred to a substance abuse clinic for treatment. If patients tested positive a second time, or if they missed an appointment with a substance abuse counselor, the police were notified immediately and patients were arrested.⁴³⁴ The government conceded that the threat of law enforcement allowed the hospital to leverage patients into treatment; however, the government defended the policy on special needs grounds. Even if the policy incorporated the threat of law enforcement, ultimately, the policy was designed to serve non-

⁴³⁰ *Id.* at 318.

⁴³¹ *Id.* at 323 (italics added).

⁴³² 532 U.S. 67 (2001).

⁴³³ *Id.* at 70.

⁴³⁴ *Id.* at 72.

law enforcement ends, namely protecting the pregnant women and their children.⁴³⁵ In an opinion by Justice Stevens, the Supreme Court held that the searches were unreasonable and indistinguishable from a general interest in crime control. Even if the ultimate goal had been to get women into substance abuse treatment, the extensive involvement of law enforcement in the development of the program, and its day-to-day administration, suggested that “the immediate objective” of the program was to secure evidence for a criminal proceeding.⁴³⁶

Since *Chandler*, it now appears that at least a handful of Justices have retreated from a strong public safety rationale for the special needs doctrine. In *Earls v. Pottawatomie County*, the most recent special needs case, a four-justice plurality described public safety as only a “factor” in a special needs analysis.⁴³⁷ In *Earls*, the plurality upheld a policy that required all middle and high school students to consent to an initial drug test, as well as random drug testing, and testing on reasonable suspicion, as a condition of participation in any extracurricular activity. While the policy upheld in *Vernonia* only applied to student athletes, the policy at issue in *Earls* required drug testing for students who participated in any extracurricular activity, including nonathletic activities such as Future Farmers of America, the Academic team, the show choir or the marching band.⁴³⁸ In an opinion by Justice Thomas, the plurality held that the school policy was not unreasonable, even without evidence that illegal drug use was a serious problem in Pottawatomie schools. Justice Thomas reiterated that

⁴³⁵ *Id.* at 81.

⁴³⁶ *Id.* at 82-83.

⁴³⁷ *Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls*, 536 U.S. 822 (2002).

⁴³⁸ *Id.* at 826.

public schoolchildren have only a diminished expectation of privacy, and the government had a strong interest in eliminating drug use, particularly among schoolchildren.⁴³⁹

i. PUBLIC ASSISTANCE AND THE FOURTH AMENDMENT

The Supreme Court has yet to address the constitutional questions that arise when states condition public assistance benefits on passing a drug test. However in *Wyman v. James*, the Supreme Court upheld a similar provision that required AFDC recipients to accept scheduled home visits by a caseworker as a condition of receiving benefits.⁴⁴⁰ In *Wyman*, the Court held that home visits by an AFDC caseworker were not searches within the meaning of the Fourth Amendment, and even if they were, home visits were not unreasonable. Writing for the Court, Justice Blackmun argued that when states distribute federal and state tax dollars through their social welfare programs they are “fulfilling a public trust,” and as such, states have an “appropriate and paramount interest” in ensuring that public dollars reach their intended beneficiaries.⁴⁴¹ Moreover, the reasonableness of the government’s interests, as well as the voluntary nature of applying for AFDC, worked together to diminish the privacy rights of Mrs. James.⁴⁴²

a. LOWER COURT DECISIONS

Yet, despite *Wyman*, lower courts have consistently invalidated efforts to condition public assistance on passing a drug test. In *Marchwinski v. Howard*, a federal district court struck down a

⁴³⁹ *Id.* at 835.

⁴⁴⁰ 400 U.S. 309 (1971).

⁴⁴¹ *Id.* at 318-19.

⁴⁴² *Id.* at 324.

pilot program that authorized random suspicionless drug testing for all TANF recipients in Michigan.⁴⁴³ Under the pilot program, TANF recipients who tested positive for a controlled substance in selected counties were required to participate in a substance abuse treatment program or risk losing their benefits. In support of the program, Michigan asserted a state interest in moving TANF recipients from welfare to work, as well as a state interest in protecting children from abuse and neglect in the homes of TANF recipients. Relying heavily on *Chandler*, the district court held that the state interest in identifying potential barriers to employment does not constitute a special need. The district court heard arguments for *Marchwinski* in 2000, before *Earls*. Without *Earls*, the district court read *Chandler* to limit the special needs doctrine to circumstances in which states are faced with a genuine threat to public safety. Nor was the district court persuaded that a state interest in preventing child abuse and neglect constituted a special need. Instead, the court reasoned that insofar as the TANF program was not designed to address child abuse and neglect, the state could not advance these interests as a special need.⁴⁴⁴

On appeal, a three-judge panel of the Sixth Circuit reversed, finding that the district court erred in holding that only a public safety interest can qualify as a special need.⁴⁴⁵ Instead, the proper standard was whether the State of Michigan demonstrated a special need “of which public safety is by one consideration.”⁴⁴⁶ Given *Earls*, the court readily concluded that suspicionless drug testing would advance a host of state interest, related and unrelated to public safety:

⁴⁴³ 113 F. Supp. 2d 1134 (E.D. Mich. 2000).

⁴⁴⁴ *Id.* at 1140.

⁴⁴⁵ *Marchwinski v. Howard*, 309 F.3d 330 (6th Cir. 2002).

⁴⁴⁶ *Id.* at 335.

We think it is beyond cavil that the state has a special need to insure that public moneys expended in the [TANF Program] are used by recipients for their intended purposes and not for procuring controlled substances—a criminal activity that not only undermines the objectives of the program but directly endangers both the public and the children the program is designed to assist.⁴⁴⁷

The court noted additional public safety interests including a state interest in protecting children in the TANF program from child abuse, as well as a state interest in protecting the public from crime associated with drug trafficking.⁴⁴⁸ However, a year later, the Sixth Circuit agreed to rehear *Marchwinski* en banc. On appeal, the full 12-judge panel of the Sixth Circuit deadlocked on the Fourth Amendment issue, 6-6. As a result, the appellate court upheld the initial district court opinion, thereby striking down drug testing for TANF applicants in Michigan.⁴⁴⁹

In November 2011, a Florida district court issued a preliminary injunction against the Florida Department of Children and Family Services (DCFS), temporarily halting the Department's ability to condition TANF benefits on a suspicionless drug test in *Lebron v. Wilkins*.⁴⁵⁰ In its defense, the State argued that drug testing TANF applicants furthered a number of state interests, foremost among them a state interest in ensuring that public funds reach their intended beneficiaries.⁴⁵¹ Second, by providing low-income children with cash assistance, the State stepped into the role of economic provider, thereby acquiring a duty to protect minor children from drug abuse in the home. Third, a drug testing requirement would allow DCFS to identify drug-related barriers to employment, thereby furthering the overarching mission of TANF: economic self-sufficiency.

⁴⁴⁷ *Id.* at 336.

⁴⁴⁸ *Id.*

⁴⁴⁹ *Marchwinski v. Howard*, 319 F.3d 258 (6th Cir. 2003).

⁴⁵⁰ *Lebron v. Wilkins*, 820 F. Supp. 2d 1273 (M.D. Fla. 2011).

⁴⁵¹ Defendant's Response to Plaintiff's Motion for Preliminary Injunction at 18, *Lebron v. Wilkins*, 820 F. Supp. 2d 1273 (M.D. Fla. 2011) (No. 6:11-cv-01473-Orl-35DAB).

Fourth, the “public health” and “crime risks” associated with the drug epidemic are well known; and the State asserted a paramount interest in not funding that epidemic as well as its associated “public ills.”⁴⁵²

In an opinion by Judge Mary Scriven, the district court rejected each of those claims primarily on the ground that the State failed to provide concrete evidence of rampant illegal drug use among TANF recipients in Florida. Well before enacting HB 353, the Florida Legislature directed DCFS to conduct a pilot study to determine whether TANF applicants are more likely to abuse drugs, and whether that abuse impacts employment and their use of social services. The pilot study found that roughly 5% of TANF applicants tested positive for drugs, a rate far less than the prevalence of statewide drug use in Florida, estimated at 8.13%.⁴⁵³ Moreover, those who tested positive for drugs during the pilot study were just as likely to work and just as likely to use social services as those who tested negative for drugs.⁴⁵⁴ Second, between July 2011 and November 2011, when drug testing began, only 2% of TANF applicants tested positive for drugs.⁴⁵⁵ Nor was the court persuaded that refusal to take a drug test after being deemed otherwise eligible should be considered a “drug related denial,” since there were any number of reasons that a person might not take a drug test—inability to pay for testing or lack of transportation—and the State was unable to provide any evidence about the why applicants failed to take a drug test.⁴⁵⁶ Finally, Judge Scriven rejected the State’s contention that data on the nationwide prevalence of drug use might have any

⁴⁵² *Id.* at 21.

⁴⁵³ *Lebron*, 277 820 F. Supp. 2d, at 1277; Robert E. Crew, Jr. & Belinda Creel Davis, *Assessing the Effects of Substance Abuse Among Applicants for TANF Benefits*, 17 J. HEALTH & SOC. POL’Y 39, 41–42, 44 (2003).

⁴⁵⁴ *Lebron*, 277 820 F. Supp. 2d, at 1277.

⁴⁵⁵ *Id.* at 1280.

⁴⁵⁶ *Id.* at 1281.

probative value on the question before the court—namely the prevalence of illegal drug use among TANF applicants in *Florida*.⁴⁵⁷ Applying the *Chandler* “concrete danger” rule, the court concluded that Florida failed to provide evidence of a “concrete danger” among the class of citizens it sought to test.⁴⁵⁸

What should we make of the court’s reasoning in *Lebron*? Even if illegal drug use among TANF applicants does not present a genuine threat to public safety, it is not at all clear that statistics on the nationwide prevalence of illegal drug use among TANF recipients are utterly lacking in probative value. Below I want to suggest that a public health perspective, along with some basic principles of risk assessment and epidemiology, can help courts determine whether states have met their burden to establish a special need.

III. A PUBLIC HEALTH PERSPECTIVE

In a widely cited and influential report, the Institute of Medicine defined public health this way: “Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”⁴⁵⁹ In contrast to general medicine, public health concerns the health of populations rather than individuals. Where traditional legal reasoning relies on non-empirical methods, such as analogical reasoning and statutory interpretation, public health practice relies on empirical evidence and epidemiological data.⁴⁶⁰ From a public health perspective, the key questions in the debate surrounding drug testing and public assistance are these: what do we know about the prevalence of

⁴⁵⁷ *Id.* at 1286-87.

⁴⁵⁸ *Id.* at 1287.

⁴⁵⁹ THE INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH (1988).

⁴⁶⁰ WENDY PARMET, POPULATIONS, PUBLIC HEALTH & THE LAW 58 (2009).

illegal drug use in the target population? What do we know about addiction? How will these policies impact the health of substance abusers and the people around them?

Since Justice Blackmun first outlined the broad strokes of the special needs doctrine in *T.L.O.*, the content of a special needs analysis has changed. Current approaches to the special needs doctrine on the Supreme Court reflect its increasing emphasis on the Reasonableness Clause. In order to determine the reasonableness of a special needs search, courts will now balance several factors—(i) the government interest in a search; (ii) the nature and intrusiveness of the search; (iii) the effectiveness of the search; and (iv) the individual interest in privacy. In keeping with the original intent of the special needs doctrine, courts will also ask whether the government interest in a suspicionless search is sufficiently divorced from a general state interest in law enforcement.

Part III will propose a public health approach to the special needs doctrine. In *Chandler*, a strong majority of Justices held that a reasonable suspicionless search requires evidence of a genuine threat to public safety. To that end, Part III.A. will propose a simple framework for risk analysis. Part III.B. will turn to the nature and intrusiveness of a special needs search. From a conventional Fourth Amendment perspective, questions about the intrusiveness of a search concern who will receive test results, whether positive tests will be turned over to law enforcement, and ultimately, whether the search falls within the scope of the special needs doctrine. From a public health perspective, however, the important issues have little to do with the *Ferguson* problems that arise when the fruits of a special needs search are turned over to law enforcement. Instead, the important questions concern the possibility that sharing information with law enforcement might be associated with an adverse effect on the health of illegal drug users and the people around them. Part III.B. will argue that by deterring people who use illegal drugs from seeking public assistance, states could actually increase the risk that children who are in abusive homes will go undetected.

Since *Vernonia*, the Supreme Court has explicitly addressed effectiveness as an element of a reasonable special needs search. Yet, courts tend to assume that drug tests are reasonably likely to accomplish their objectives.⁴⁶¹ Instead, Part III.C. will argue that courts should assume a more aggressive posture when evaluating the effectiveness of a search under the special needs doctrine. Although drug testing would allow states to effectively identify illegal drug users in their public assistance programs, withholding public assistance benefits as penalty for illegal drug use will do very little to help people stop using drugs. Pushing drug users out of the social safety net could have an adverse impact on population health by driving an already marginalized group further underground. Part III.C. will propose that the current approach to the special needs doctrine is faulty in one further respect—the failure to incorporate the least intrusive alternative requirement into the special needs doctrine. Although the Supreme Court has consistently said that the Fourth Amendment does not require governments to adopt the least intrusive means to accomplish their objectives, without incorporating the least intrusive alternative requirement into the special needs doctrine, special needs searches are needlessly overinclusive.

Part III.D. will consider the individual interest in privacy. Courts may well conclude that the privacy interests implicated by suspicionless drug tests are negligible. However, Part III.D. will show that suspicionless drug tests implicate more than the individual interest in privacy. A large literature on social epidemiology has shown that encounters with the law can be a powerful marker of social status, with implications for our health.

A. THE GOVERNMENT INTEREST

In *Chandler*, the Supreme Court held that a lawful suspicionless search requires a genuine threat to public safety: “We reiterate, too, that where the risk to the public safety is substantial and

⁴⁶¹ GOSTIN, *supra* note 341, at 63 (2008).

real, blanket suspicionless searches calibrated to the risk may rank as ‘reasonable’ but where “public safety is not genuinely in jeopardy, the Fourth Amendment precludes the suspicionless search, no matter how conveniently arranged.”⁴⁶² From a public health perspective, we can understand risk as a composite of two factors—the probability of a harm, and the magnitude of the harm if it were to occur. In this paper, I will use the term probability of the harm unconventionally to refer to the probability that an adverse event such as illegal drug use will occur. By magnitude of the harm, I mean the nature and severity of the harm if it were to occur. In the latter category, I will include harms associated with illegal drug use such as the misuse of taxpayer dollars to purchase illegal drugs, harms to drug users themselves, and harms to others such as child abuse and neglect.

i. THE PROBABILITY OF THE HARM

1. NATIONAL ESTIMATES

Most nationally representative estimates of illegal drug use in the United States have found that roughly 1 in 5 TANF recipients report illegal drug use at some point during the past year.⁴⁶³ These findings also appear to be consistent over time. Using 1994 ’95 data from the National Household Survey of Drug Abuse (NHSDA), Jayakody and colleagues found that 21 percent of TANF recipients reported use of an illegal drug during the past year, compared to 13 percent of non-recipients.⁴⁶⁴ Excluding marijuana, about 10 percent of TANF recipients reported use of some other illegal drug during the past year, compared to 7 percent of non-recipients, however, as the

⁴⁶² Chandler v. Miller, 520 U.S. 305, 323 (1997).

⁴⁶³ Lisa A. Metsch & Harold A. Pollack, *Welfare Reform and Substance Abuse*, 83 MILLBANK Q. 65, 68 (2005).

⁴⁶⁴ Rukmalie Jayakody et al., *Welfare Reform, Substance Abuse, and Mental Health* 25 J. HEALTH POL., POL’Y & L. 623 (2000).

researchers caution these differences were not statistically significant.⁴⁶⁵ Similarly, using 2002 data from the National Survey of Drug use and Health—the successor to the NHSDA—Pollack and colleagues found that 22.3 percent of TANF recipients ages 18-19 reported illegal drug use during the previous year compared to 12.8 percent of women who did not receive TANF benefits.⁴⁶⁶

Still, as opponents of drug testing will argue, not all studies based on nationally representative data suggest that approximately 1 in 5 recipients of public assistance use illegal drugs. In 2002, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that the prevalence of past month illicit drug use among people in households receiving cash assistance through TANF was somewhat higher than the prevalence of drug use among non-recipients: 11.5% compared to 7.2%.⁴⁶⁷ Nor did the study find twofold gaps in the prevalence of illegal drug use among recipients of public assistance. The prevalence of past month illicit drug use among recipients of public assistance—not limited to TANF—was somewhat higher, though by not much: 9.6% compared to 6.8%.⁴⁶⁸

2. STATE ESTIMATES

For opponents of drug testing, findings from state experiments with drug testing also cast doubt on claims that roughly 1 in 5 TANF recipients use illegal drugs. In October 1999, Michigan

⁴⁶⁵ *Id.* at 638.

⁴⁶⁶ Harold Pollack, et al., *Drug Testing Welfare Recipients—False Positive, False Negatives, Unanticipated Opportunities*. 12 WOMEN'S HEALTH ISSUES 23 (2002).

⁴⁶⁷ OFFICE OF APPLIED STATISTICS, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN, SUBSTANCE ABUSE AMONG PERSONS IN FAMILIES RECEIVING GOVERNMENT ASSISTANCE, Table 1 (2002).

⁴⁶⁸ *Id.*

implemented mandatory drug testing for TANF recipients.⁴⁶⁹ Under the statute, all TANF recipients were required to pass a urine test as a condition of assistance. Between October and November 1999, when drug testing ended under an injunction, 258 TANF recipients were tested for drugs. Of those 258 recipients, 21 (8.1%) tested positive. Of those who tested positive, 18 tested positive for marijuana alone, and 3 tested positive for “hard drugs” including cocaine and amphetamine.⁴⁷⁰ The rate of illegal drug use detected among TANF recipients in Michigan was also comparable to the 1999 prevalence of drug use within the state population as a whole (7.1%) leading opponents to argue that states like Michigan are wrongly singling TANF recipients out for a drug test.⁴⁷¹

What should we make of these claims? First, we might worry that findings from states like Michigan fail to provide a valid estimate of drug use among TANF recipients. Since drug testing proposals are well advertised, opponents of drug testing cannot rule out the possibility that although most TANF recipients do not use drugs, those who do use illegal drugs either refrained from doing so prior to taking the test, or simply elected not to apply for benefits. In Florida, the pilot study for HB 353 found that 5% of TANF applicants tested positive for drugs; however, as the researchers readily concede, the study suffered from a number of methodological problems.⁴⁷² In addition to a possible deterrent effect from advertising, during the pilot study, only those applicants who were predicted to have a substance abuse problem using the Substance Abuse Subtle Screening Inventory

⁴⁶⁹ Metsch & Pollack, *supra* note 463, at 76.

⁴⁷⁰ *Id.*

⁴⁷¹ Matt Lewis & Elizabeth Kenefick, RANDOM DRUG TESTING OF TANF RECIPIENTS IS COSTLY, INEFFECTIVE AND HURTS FAMILIES, <http://www.clasp.org/admin/site/publications/files/0520.pdf>; SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., NATIONAL SURVEY ON DRUG USE & HEALTH, Table 2B (1999).

⁴⁷² Crew & Davis, *supra* note 453 at 45-46.

(SASSI) were asked to take a drug test. A false positive rate of 7% would mean that the SASSI failed to identify 335 individuals as potential candidates for a drug test; however, since the SASSI screens for both alcohol and drug abuse, we cannot know how many of those 335 individuals might have tested positive for drugs.⁴⁷³

In *Lebron*, Judge Scriven concluded that Florida could only provide evidence that somewhere between 2 and 5 percent of TANF applicants have used illegal drugs, and therefore the government failed to demonstrate a “concrete danger” of illegal drug use among TANF recipients. However, owing to enrollment bias and deterrent effects, findings from pilot studies and early testing probably underestimate the actual prevalence of illegal drug use among TANF applicants in Florida. Even if the prevalence of illegal drug use among TANF applicants in Florida is not as high as 20 or 11 percent, it seems unlikely that only 2 or 5 percent of TANF recipients have used illegal drugs, a rate far below the state average of roughly 8 percent.

In *Lebron*, the district court also faulted Florida for relying on national estimates of illegal drug use and failing to provide robust Florida-specific evidence about the prevalence of drug use among TANF applicants.⁴⁷⁴ However, from a public health perspective, what we want to know is whether findings based on national household surveys of illegal drug use are generalizable to Florida. John Monahan and Laurens Walker have shown that questions about generalizability in social science bear a close resemblance to reasoning by analogy in the law.⁴⁷⁵ Just as courts will view precedents as “on point” to the extent that they involve similar facts, questions about external validity or generalizability concern the degree of similarity between the people under study and the

⁴⁷³ *Id.*

⁴⁷⁴ *Id.* at 1278.

⁴⁷⁵ John Monahan & Laurens Walker, *Social Authority: Obtaining, Evaluating and Establishing Social Science in Law*, 13 U. PA. L. REV. 477, 506 (1986).

people to whom courts wish to generalize.⁴⁷⁶ Moreover, just as courts would not rely on decisions that are poorly reasoned, or decisions that have fallen into disfavor, courts can rely on a particular piece of scientific evidence to the extent that it has survived the process of peer review, it has employed valid research methods, and it is supported by further research.⁴⁷⁷

Despite being a coastal state and an entry point for drug smuggling into the United States, illicit drug use in Florida closely resembles the national average. According to the 2002 National Survey on Drug Use and Health, 8.84% of Floridians age 12 or older reported use of an illicit drug during the past month, compared to a national average of 8.3%.⁴⁷⁸ Using data from the same survey, Pollack and colleagues found that roughly 20 percent of TANF recipients reported illicit drug use during the past year.⁴⁷⁹ Based on this evidence we can infer that the prevalence of past year illegal drug use among TANF recipients in Florida is probably somewhere around 20 percent.

3. A PRECAUTIONARY PRINCIPLE?

In *Lebron*, Florida argued that it could establish a special governmental need for drug testing without evidence of an “overwhelming drug problem.”⁴⁸⁰ In support of its contention, the government relied heavily on *Von Raab*, where the Supreme Court upheld suspicionless drug testing for customs agents involved in drug interdiction, without any evidence that illegal drug use was a

⁴⁷⁶ *Id.*

⁴⁷⁷ *Id.* at 499.

⁴⁷⁸ OFFICE OF APPLIED STATISTICS, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, RESULTS FROM THE 2002 NATIONAL SURVEY ON DRUG USE & HEALTH, Appendix A, Table A.1 (2003).

⁴⁷⁹ Pollack et al., *supra* note 466.

⁴⁸⁰ *Lebron v. Wilkins*, 820 F.Supp.2d 1273, 1287 (M.D. Fla. 2011).

serious problem among customs agents. Likewise in *Lebron*, the government alluded to *Earls*, where a plurality of the Court upheld suspicionless drug testing for high school students involved in nonathletic extracurricular activities, again with very little evidence of illegal drug use among these students, but instead on the ground that illegal drug use presents a safety risk for all children, “athletes and nonathletes alike.”⁴⁸¹ Writing for the plurality in *Earls*, Justice Thomas reasoned: it would “make little sense” to require school districts to wait for a substantial portion of their school body to use drugs before instituting a drug testing program.⁴⁸²

What should we make of these claims? As Lawrence Gostin writes, “if there is one article of faith in public health,” it is that public health regulation should be based on “risks that are significant, not speculative, theoretical or remote.”⁴⁸³ Without a clear understanding of a public health hazard, interventions are unlikely to be effective and run a risk of imposing needless economic costs and personal burdens.⁴⁸⁴ At the same time, communities will sometimes face hazards that are not fully understood, but require immediate intervention nonetheless.⁴⁸⁵ In public health, the precautionary principle provides a principled basis for preventive measures designed to protect the public’s health under conditions of uncertainty.

The precautionary principle has its origins in environmental health. A widely cited formulation of the precautionary principle can be found in the 1992 United Nations Rio Declaration

⁴⁸¹ Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls, 536 U.S. 822, 836 (2002).

⁴⁸² *Id.*

⁴⁸³ GOSTIN, *supra* note, 341 at 73, 57.

⁴⁸⁴ *Id.* at 73.

⁴⁸⁵ *Id.*

on Environment and Development. As formulated by the U. N., and adopted by member states, including the United States, the precautionary principle provides:

Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.⁴⁸⁶

The precautionary principle permits policymakers to implement precautionary regulation when there are early warning signs that a harm is occurring or is likely to occur, even though the precise causal mechanisms of that harm are not fully understood.⁴⁸⁷ In environmental health, the precautionary principle shifts the burden of proof onto proponents of an activity to demonstrate that the proposed activity would not result in a serious or potentially irreversible harm.⁴⁸⁸ Absent such evidence, the precautionary principle permits preventive regulation geared toward protecting public health. In support of greater precautionary measures, proponents of the precautionary principle often cite examples of risks that were underestimated but later turned out to be highly damaging to human health, including asbestos, leaded gasoline, and chlorofluorocarbons (CFCs).⁴⁸⁹

What would the precautionary principle imply for the special needs doctrine? Ordinarily a reasonable government search requires a warrant, and if not a warrant, a reasonable search ordinarily requires probable cause or a reasonable suspicion of wrongdoing. Nevertheless, as Justice Kennedy observed in *Von Raab*, the traditional probable cause standard may be unhelpful when “the Government seeks to *prevent* the development of hazardous conditions” or to detect violations that

⁴⁸⁶ UNITED NATIONS CONFERENCE ON ENVIRONMENT AND DEVELOPMENT. RIO DECLARATION ON ENVIRONMENT AND DEVELOPMENT (1992).

⁴⁸⁷ Joel A. Tickner et al., *A Compass for Health: Rethinking Precaution and Its Role in Science and Public Health*, 32 INT’L. J. EPIDEMIOLOGY 489 (2003).

⁴⁸⁸ Noah M. Sachs, *Rescuing the Strong Precautionary Principle From Its Critics*, 2011 U. ILL. L. REV. 1285, 1288 (2011).

⁴⁸⁹ Gary E. Marchant, *From General Policy to Legal Rule: Aspirations and Limitations of the Precautionary Principle*, 111 ENVTL. HEALTH PERSP. 1799 (2003).

rarely generate articulable grounds for a search.⁴⁹⁰ We can understand the special needs doctrine as an attempt to organize the murky territory between searches falling short of probable cause and reasonable suspicion but above the Fourth Amendment threshold of unreasonableness.

Although the Supreme Court has been criticized for failing to recognize the many ways in which the law can be used as a tool to protect population health, in its special needs cases, the Supreme Court appears to have the opposite problem—a tendency to be overly solicitous when governments assert an interest in public health or public safety. A tendency to overemphasize small risks to public health led the Court to uphold suspicionless fire safety inspections for householders in *Camara*, and suspicionless drug tests for customs agents in *Von Raab*. Before pressing on to consider what the precautionary principle might imply for drug testing and public assistance, it may be helpful to pause and reconsider the drug testing cases from a public health perspective.

In *Von Raab*, the Supreme Court cited the “extraordinary safety and national security hazards” associated with the promotion of illegal drug users to positions involving drug interdiction or to positions that would require them to carry firearms.⁴⁹¹ However, the case for precautionary measures fails in *Von Raab*, owing to the low risk harm. Above I said that we can understand risk as a combination of two factors—the probability of a harm and the magnitude of the harm if it were to occur. Notwithstanding routine exposure to criminal elements and access to valuable sources of contraband, the probability of illicit drug use among customs agents was exceptionally low. According to the Customs Service, of the 3,600 employees who tested positive for drugs, only 5 employees—less than 1/10 of 1 percent—tested positive.⁴⁹²

⁴⁹⁰ *Von Raab*, 489 U.S. 656, 668 (1989).

⁴⁹¹ *Id.* at 674.

⁴⁹² *Id.* at 673.

By itself, a low probability of harm should not lead courts to conclude that the government has failed to establish a genuine public health threat. Courts must also consider the severity of a harm if it were to occur. Although the number of airline passengers and pieces of luggage screened by the Federal Aviation Administration reaches into the billions, only a few thousand firearms have been detected and only a few plans have been successfully hijacked.⁴⁹³ Even though the probability of an undetected firearm or a successful hijacking is extraordinarily low, the consequences of a false negative (a missed firearm or a successful hijacking) would be very high—hundreds of human lives lost, countless injuries, and millions of dollars in property damage. In cases like this one, where the severity of harm is great with long-lasting and potentially devastating consequences across populations, governments can establish genuine threats to public safety notwithstanding a low probability of wrongdoing. By contrast, the harm associated with failure to interdict a drug shipment is fairly low—primarily drug-related morbidity and some mortality. The combination of a near zero probability of harm and the small magnitude of harm greatly undermines the case for suspicionless drug testing.

In contrast to *Von Raab*, the case for precautionary measures becomes stronger in *Vernonia*, where the Supreme Court upheld suspicionless drug testing for middle and high school students who participated in athletic activities. In *Vernonia*, the government was able to provide a wealth of evidence to support its claims regarding the extent of illegal drug use in Vernonia schools—students began to boast about drug use and the inability of school administrators to stop them; teachers reported direct observation of student drug use and confiscated drug paraphernalia on school grounds.⁴⁹⁴ Coaches also reported an increase in the number and severity of injuries. A few

⁴⁹³ *Id.* at 675, n. 3.

⁴⁹⁴ *Acton v. Vernonia Sch. Dist.*, 796 F. Supp. 1354, 1356-57 (D. Or. 1992).

students went so far as to form recreational groups around their drug use. One group, composed largely of student athletes, referred to itself as the “Big Elks,” another referred to itself as the “Drug Cartel.”⁴⁹⁵ The evidence in *Vernonia* pointed toward a substantial probability of drug use in *Vernonia* schools, as well as among the class of students administrators sought to test. In contrast to *Von Raab*, where the connection between drug use and population health was highly attenuated and speculative at best, in *Vernonia* the government was able to advance a plausible hypothesis that in a small community where interscholastic activities provided the primary source of entertainment, drug use among student athletes could fuel a “role model effect,” encouraging other students to use drugs.⁴⁹⁶ School administrators were able to provide credible evidence that the combination of illegal drug use and exercise could result in serious, potentially deadly harms.⁴⁹⁷

In contrast to *Vernonia*, the case for precaution fails entirely in *Earls*. School administrators were only able to provide minimal evidence of illegal drug use, primarily—testimony from teachers who had observed students who appeared to be under the influence of drugs; marijuana cigarettes in the school parking lot; and drug paraphernalia found in a car driven by a student member of the Future Farmers of America.⁴⁹⁸ Nor was the government able to provide much in the way of a causal connection between illegal drug use and harm. Quite unlike the students at issue *Vernonia* where the combination of illegal drug use and physical exertion could create substantial health risks, in *Earls*, the plurality upheld suspicionless drug testing for students involved in nonathletic extracurricular

⁴⁹⁵ *Id.* at 1357.

⁴⁹⁶ *Id.* at 1363.

⁴⁹⁷ *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 662 (1995).

⁴⁹⁸ *Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls*, 536 U.S. 822, 834-35 (2002).

activities like show choir and the debate team, where the magnitude of potential harm would be comparatively low.

ii. THE NATURE AND SEVERITY OF THE HARM

1. TAXPAYER SUBSIDY OF ILLEGAL DRUG USE

What would the precautionary principle imply for drug testing and public assistance? Above I argued that the prevalence of illegal drug use among TANF recipients in Florida is probably somewhere around 20 percent. However, even if the prevalence of illegal drug use among TANF recipients is roughly 20 percent, that would mean that 80 percent of TANF recipients have *not* reported illegal drug use, and yet, as the court pointed out in *Lebron*, all are required to submit to a drug test.⁴⁹⁹ There are circumstances in which we might be prepared to tolerate a blanket suspicionless search—e.g. a suspicionless search of all airline passengers and their carry-one luggage—because even if the probability of the harm is very low, the potential harm is very great. In contrast, to the airplane case, however, the harm associated with a taxpayer subsidy of illegal drug use is small—primarily a few thousand in lost taxpayer dollars. In Florida, it appears that HB 353 has actually cost taxpayers more money than it has saved. Florida law requires the state to reimburse applicants who test positive for drugs. According to the Department of Children and Family Services, at an average cost of \$30 per test, the total reimbursement cost to the state was \$118,140.⁵⁰⁰ DCFS estimates that HB 353 has cost the state an additional \$45,780, since the reimbursement costs

⁴⁹⁹ *Lebron v. Wilkins*, 820 F.Supp.2d 1273, 1281 (M.D. Fla. 2011).

⁵⁰⁰ Lizette Alvarez, *No Savings Are Found From Welfare Drug Tests*, N.Y. TIMES, Apr. 17, 2012, at A14.

were far more than the state would have spent on income assistance had it provided benefits to the 108 people who failed the test.⁵⁰¹

Those who continue to support a drug testing requirement nonetheless offer two replies to these findings. First, the real reason to require TANF applicants to pass a drug test was to ensure that taxpayer dollars are spent on “diapers and Wheaties” rather than illegal drugs.⁵⁰² Without a drug test, states cannot be sure that taxpayer dollars will reach their intended beneficiaries. Second, states have a basic interest in ensuring that taxpayer dollars are not used to fund an illegal activity. In support of a drug testing law in Oklahoma, Representative Liebmann put it this way:

Even if it didn’t save a dime, this legislation would be worth enacting based on principle....Law abiding citizens should not have their tax payments used to fund illegal activity that puts us all in danger.⁵⁰³

However, to the extent that states rest the case for drug testing on principle, arguments of this kind come dangerously close to resting the case for suspicionless drug testing on a symbolic interest, an interest forcefully rejected by eight Justices in *Chandler*. In response, those who support a drug testing requirement might argue, as some have, that “[t]he drug testing law was really meant to make sure that kids were protected,” or to make sure that taxpayer dollars reach their intended beneficiaries, the latter being a government interest endorsed by the Court in *Wyman*.⁵⁰⁴ However, in *Wyman*, the Supreme Court addressed the constitutionality of home visits by a caseworker, not a drug test.

⁵⁰¹ *Id.*

⁵⁰² *Id.*

⁵⁰³ Jennifer Cope, PROPOSED HOUSE BILL WOULD DRUG TEST RECIPIENTS OF GOVERNMENT ASSISTANCE, <http://www.ktul.com/story/17139440/proposed-house-bill-would-drug-test-recipients-of-government-assistance> (last visited Jun. 3, 2012).

⁵⁰⁴ Alvarez, *supra* note 500, at A14.

In *Chandler*, the Supreme Court held that “the proffered special need” for a drug test must be “substantial.”⁵⁰⁵ The Court defined the term substantial as a government interest that is both “important enough to override the individual interest in privacy” and “sufficiently vital to suppress the Fourth Amendment’s normal requirement of individualized suspicion.”⁵⁰⁶ Even if the Supreme Court were to hold that the special needs doctrine encompasses government interests beyond an interest in public safety, the government interest in ensuring that taxpayer dollars are used as intended falls far short of “substantial” within the meaning of *Chandler*. Courts are unlikely to find that the government interest in ensuring that taxpayer dollars are used as intended is “sufficiently vital” to suppress the individualized suspicion requirement. As Justices O’Connor, Souter and Stevens argued in their *Vernonia* dissent, “[f]or most of our constitutional history, mass, suspicionless searches have generally been considered *per se* unreasonable within the meaning of the Fourth Amendment.”⁵⁰⁷ Indeed the abuses associated with “general searches” were foremost on the minds of the Framers.⁵⁰⁸ If the Supreme Court were to hold that the government interest in ensuring that taxpayer dollars are used as intended is sufficient to suppress the Fourth Amendment’s ordinary requirement of individualized suspicion, doing so would amount to a vast expansion of government power.

⁵⁰⁵ *Chandler v. Miller*, 520 U.S. 305, 319 (1997).

⁵⁰⁶ *Id.*

⁵⁰⁷ *Vernonia*, 515 U.S. at 667 (O’Connor, J., dissenting).

⁵⁰⁸ *Id.* at 669.

2. CHILD ABUSE AND NEGLECT

Supporters of drug testing have also argued that a state interest in preventing child abuse and neglect in the homes of TANF recipients constitutes a special need. In *Lebron*, Florida connected substance abuse among TANF recipients to adverse consequences for their children:

A parent using drugs is less able to care for their children properly (neglect), is more likely to actively harm a child (abuse), is less able to procure and maintain employment, is more likely to come in contact with the criminal justice system and thus be removed from the home, and is more likely to set an inappropriate example for children and also provide those children with easier access to drugs (who, thus, might more readily abuse illegal drugs).⁵⁰⁹

Many studies have shown that parental substance abuse can have a negative impact on children. According to the U.S. Department of Health and Human Services, between one and two-thirds of children who have been reported to child protective services come from families coping with substance abuse.⁵¹⁰ Children whose parents abuse drugs often experience a home that is chaotic and unpredictable.⁵¹¹ Children whose parents abuse drugs are also more likely to experience physical violence and sexual abuse.⁵¹² Yet, despite the devastating impact of substance abuse on children, the case for suspicionless drug testing is not without its problems. The special needs doctrine applies when governments face special needs *beyond* the normal need for law enforcement. To the extent that states rest the case for suspicionless drug testing on a state interest in protecting children from acts of drug-related violence in the home—battery and sexual assault—they have asserted an interest in law enforcement.

⁵⁰⁹ Defendant's Response, *supra* note 451 at 20.

⁵¹⁰ U.S. DEPT OF HEALTH & HUMAN SERVICES. BLENDING PERSPECTIVES AND BUILDING COMMON GROUND: A REPORT TO CONGRESS ON SUBSTANCE ABUSE AND CHILD PROTECTION (1999).

⁵¹¹ CENTER ON ADDICTION & THE FAMILY. EFFECTS OF SUBSTANCE ABUSE ON CHILDREN AND FAMILIES <http://www.coaf.org/professionals/effects%20.htm> (last visited Jun. 3, 2012).

⁵¹² *Id.*

What should we say about the case for child abuse as special governmental need from a public health perspective? Although studies have shown that 1 in 5 TANF recipients report use of an illegal drug during the past year, there is little evidence to suggest that parents who receive public assistance are more likely to engage in acts of drug-related child abuse than others. Studies have shown that parental substance abuse and dependence increase the risk of child abuse; yet, only a small percentage of TANF recipients meet the diagnostic criteria for substance abuse or dependence. Using 2002 data from the National Survey on Drug Use and Health, Pollack and colleagues found that less than 5% of TANF recipients satisfied the diagnostic criteria for drug dependence.⁵¹³

In *Lebron*, Florida also argued that by providing income assistance to low-income families, the state “steps into the role of parent” or “economic provider,” and therefore, the state takes on a special responsibility to ensure that TANF funds are not used to subsidize drug use in the home.⁵¹⁴ To that end, Florida relied on *Vernonia*, where the Supreme Court held that suspicionless drug testing policies were not unreasonable given the custodial responsibilities of public schools for minor children in their care.⁵¹⁵ However, Florida’s reliance *Vernonia* is misplaced. In both *Vernonia* and *Earls*, the Court described the custodial responsibilities of schools with respect to extracurricular activities on school grounds or school-sponsored field trips. In neither case did the Court suggest that the custodial responsibilities of schools extend into the home. Even if states did assume some special responsibility for the children of TANF recipients, neither *Vernonia* nor *Earls* suggest that a

⁵¹³ Pollack et al., *supra* note 466; See also Bridget F. Grant & Deborah A. Dawson, *Alcohol and Drug Use, Abuse and Dependence Among Welfare Recipients*, 86 AM. J. PUB. HEALTH 1450, 1453 (1996) (finding that less than 4 percent of AFDC recipients met the DSM-IV criteria for drug dependence, compared to a general population rate of less than 2 percent among people who did not receive welfare benefits); See also Jayakody et al., *supra* note 464 (finding that less than 5% of self-reported substance users met the DSM-IV criteria for drug dependence).

⁵¹⁴ Defendant’s Response, *supra* note 451 at 20-1.

⁵¹⁵ *Id.*

concern for the wellbeing of children would support a state interest in requiring their parents to pass a drug test.

3. DRUG USE, EMPLOYMENT AND PUBLIC HEALTH

In their defense, several states including—Alabama, Kansas, Michigan, Oklahoma, and Florida—note that the federal government conditions TANF funding on a state’s ability to move TANF recipients from welfare to work.⁵¹⁶ Since the employers who participate in TANF programs are likely to require a drug test—and since illegal drug use undermines employability—states have a “special need” to exclude illegal drug users from the program.⁵¹⁷ Yet, the Supreme Court has never suggested that a state interest in securing a steady funding stream constitutes a special governmental need. Nor are courts likely to see government interests of this kind as “substantial” within the meaning of *Chandler*.

Nor is there much evidence to support state claims that the handful of TANF recipients who do use illegal drugs are likely to loll on welfare rolls for extended periods of time. According to the Department of Health and Human Services, roughly two-thirds of illegal drug users are employed either full time or part time⁵¹⁸ The pilot study for HB 353 in Florida found that drug users were employed at the same rate as non-users.⁵¹⁹ Drug users earned approximately the same amount of money as non-users and they did not require more government assistance than non-

⁵¹⁶ Brief of the States of Alabama, Michigan, et al., *supra* note 335 at 4.

⁵¹⁷ *Id.* at 10.

⁵¹⁸ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, RESULTS FROM THE 2010 NATIONAL SURVEY ON DRUG USE AND HEALTH: SUMMARY OF NATIONAL FINDINGS (2011).

⁵¹⁹ Crew & Davis, *supra* note 453 at 52; *see also* Robert E. Crew & Belinda Creel Davis, *Substance Abuse as a Barrier to the Employment of Welfare Recipients*, 5 J. POL’Y REV. 69 (2006).

users.⁵²⁰ Although studies have shown that drug abuse and drug dependence are associated with unemployment, casual or intermittent drug use does not appear to be associated with long periods of unemployment.

In *Marchwinski v. Howard*, a three-judge panel of the Sixth Circuit indicated that the public safety risks stemming from crime associated with illegal drug use and drug trafficking are either themselves a special need or at least a relevant consideration when determining whether states have meet their burden to establish a special need.⁵²¹ Picking up this thread in *Lebron*, Florida counted among its special needs the “public health” and “crime risks” associated with the drug epidemic.⁵²² To that end Florida asserted an interest in not funding that epidemic and its associated “public ills.”⁵²³ Although the public health and crime risks associated with illegal drug use are well known, there is little or no evidence that welfare recipients are important contributors to the drug problem. Without a genuine threat to public health or public safety, states cannot meet their burden to establish a special need.

B. THE NATURE AND INTRUSIVENESS OF THE SEARCH

Courts will also consider the nature of the search. Most states have proposed to test welfare recipients for drugs using a urine test. In each of the special needs cases where the Court has upheld drug testing policies, urine samples were monitored by “listening for normal sounds of urination,”

⁵²⁰ *Id.*

⁵²¹ *Marchwinski v. Howard*, 309 F.3d 330, 336 (6th Cir. 2002).

⁵²² Defendant’s Response *supra* note 451, at 21.

⁵²³ *Id.*

either behind a closed stall or by standing directly behind the person producing a urine sample, but not under direct observation.⁵²⁴ Consistent with *Skinner* and *Von Raab*, Florida law would not require laboratories to monitor TANF applicants as they produce urine samples under direct observation. Instead Florida law simply instructs the Department of Children and Family Services (DCFS) to provide each person with a “reasonable degree of dignity” consistent with the state’s interest in obtaining a reliable sample.⁵²⁵ Provided that states do not require direct observation of a urine sample, and limit testing to illegal drugs, courts are likely to conclude that the privacy interests comprised by obtaining a urine sample are negligible.

More difficult questions arise with respect to the intrusiveness of a drug test. The Supreme Court has said that the intrusiveness of a special needs search concerns whether test results are disclosed only to a limited class of personnel who have a “need to know” and whether test results are turned over to law enforcement.⁵²⁶ Courts will also ask whether sharing test results with third parties would violate a reasonable expectation of privacy held by the class of persons to be tested. At least a few states have considered the possibility of sharing positive drug test results with child protective services and law enforcement. Before a federal district court issued a preliminary injunction, temporarily halting Florida’s drug testing program in November 2011, HB 353 allowed the Department of Children and Family Services to enter drug test results into a database accessible by law enforcement agencies.⁵²⁷ Florida also indicated its intention to report test results to the

⁵²⁴ *Vernonia Sch. Dist. 47J v. Acton*, 515 U.S. 646, 650 (1995).

⁵²⁵ F.L.A. STAT. §414.0652 (2)(f) (2012).

⁵²⁶ *Vernonia School Dist. 47J*, 515 U.S. at 658.

⁵²⁷ *Lebron v. Wilkins*, 820 F.Supp.2d 1273, 1283 (M.D. Fla. 2011).

Florida Child Abuse Hotline.⁵²⁸ However, in February 2012, the Florida Department of Children and Family Services retreated from its earlier position. Instead, DCFS has published a new rule, indicating that the Department will not report test results to the Child Abuse Hotline, nor will DCFS share test results with law enforcement.⁵²⁹

The Supreme Court has provided uncertain and conflicting guidance as to whether drug test results obtained through the special needs doctrine can be shared with law enforcement agencies or child protective services. The following section will argue that courts should prohibit the use of special needs evidence in criminal prosecutions. However, even if these provisions are not unconstitutional, states should consider the possibility that by driving at-risk parents away from public assistance programs, these statutes could actually make it more difficult for child welfare agencies to identify children who are risk for abuse and neglect.

i. A FOURTH AMENDMENT PERSPECTIVE

In its classic formulation, the special needs doctrine permits suspicionless searches when governments confront special needs, “beyond the normal need for law enforcement.”⁵³⁰ However, in its early special needs cases, the Supreme Court appeared untroubled when the fruits of a special needs search were used in subsequent criminal proceedings.⁵³¹ In *T.L.O.*, Justice Blackmun did not object when prosecutors charged T.L.O. with juvenile delinquency based on evidence of drug

⁵²⁸ *Id.*

⁵²⁹ FLA. ADMIN. CODE ANN. r.65A-4.221 (2012).

⁵³⁰ *Infra* pp. 6-12.

⁵³¹ Tracey Maclin, *Is Obtaining an Arrestee's DNA a Valid Special Needs Search Under the Fourth Amendment? What Should (and Will) the Supreme Court Do?* 33 J.L. MED & ETHICS 165, 179 (2006).

dealing seized from her purse. Nor did Justice Scalia object in *Griffin* when police officers searched Griffin's home and prosecutors used a gun seized in that search to charge Griffin with a weapons offence. In *Skinner*, the Supreme Court also upheld federal regulations that authorized the release of drug test results to law enforcement. However, since there was no evidence that the federal regulations were merely a "pretext" for law enforcement, in a footnote, Justice Kennedy indicated that the Court would "leave for another day" the hard questions that would arise if prosecutors were to use evidence from a special needs search in a criminal prosecution.⁵³²

Despite *T.L.O.*, *Skinner*, and *Griffin*, in its more recent special needs cases, the Supreme Court has also suggested that handing test results over to law enforcement officials would impugn an otherwise valid administrative scheme. In *Von Raab*, *Vernonia* and *Earls*, the Justices underscored that test results were not disclosed beyond the limited class of personnel who had a need to know, nor were test results used for punitive or disciplinary purposes.⁵³³ In *Ferguson v. City of Charleston*, Supreme Court struck down state regulations that permitted drug tests for obstetrics patients, without their consent and without a reasonable suspicion of drug use, owing to the excessive entanglement of law enforcement in the creation and execution of the policy. In an opinion by Justice Stevens, the Court distinguished the ultimate purpose of a special needs search from its immediate objectives: "While the ultimate goal of the program may well have been to get the women in question into substance abuse treatment and off of drugs, the immediate objective of the searches was to generate evidence *for law enforcement purposes* in order to reach that goal."⁵³⁴ Program guidelines

⁵³² *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 621 n.5 (1989).

⁵³³ *Von Raab* 489 U.S. 656, 666 (1989); *Acton v. Vernonia School Dist.* 47J, 515 U.S. 646, 658 (1995); *Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls*, 536 U.S. 822, 833 (2002).

⁵³⁴ *Ferguson v. City of Charleston*, 532 U.S. 67, 83 (2001) (*italics in the original*).

with detailed instructions on chain of custody, the range of possible charges for drug use, and the logistics of police intervention all pointed toward the conclusion that the program in question was “specifically designed” to gather admissible evidence for a criminal prosecution.⁵³⁵

In *Ferguson*, Justice Stevens indicated that the “critical difference” between the hospital drug testing policy on the one hand, and previous special needs cases on other, was that in each of the previous cases, the special need for drug testing was “divorced from the State’s general interest in law enforcement.”⁵³⁶ In *Vernonia*, for example, the Court held that the School District instituted a drug testing policy for “distinctly *nonpunitive* purposes,” namely protecting student athletes from drug-related injury and deterring illegal drug use among students.⁵³⁷ In *Skinner*, the Court held that Federal Railroad Administration required drug tests to prevent train accidents and fatalities, “not to assist in the prosecution of employees.”⁵³⁸

At times proponents of drug testing have alluded to state interests that appear to be distinguishable from a general state interest in law enforcement, for example, a state interest in ensuring that taxpayer dollars reach their intended beneficiaries, or eliminating drug-related barriers to employment. Nonetheless, throughout the debate surrounding drug testing and public assistance, states have largely rested the case for drug testing on a state interest in ensuring that taxpayer dollars are not used to subsidize illegal drug use. In *Lebron*, Florida put it this way:

⁵³⁵ *Id.* at 84.

⁵³⁶ *Id.*

⁵³⁷ *Vernonia School Dist. 47J*, 515 U.S. at 658.

⁵³⁸ *Skinner* 489 U.S. 602, 620 (1989).

[T]he government has spent untold resources over the last thirty years fighting the “war on drugs.” Surely, then, the government has a paramount interest in *not* funding the drug epidemic and its associated public ills.⁵³⁹

To the extent that states have asserted an interest in not funding illegal activity, opponents of drug testing might argue that states have failed to demonstrate that the primary purpose of drug testing is to further a valid non-law enforcement interest. However, notwithstanding *Ferguson*, the Supreme Court has also said that a lawful suspicionless search may serve multiple purposes, including a state interest in law enforcement. In *New York v. Burger*, the Court confronted the mirror image of *Ferguson*—the primary purpose of the search was administrative, but authorities also discovered evidence of criminal conduct in the process.⁵⁴⁰ Ironically, in an opinion by Justice Blackmun, the Supreme Court upheld a New York statute designed to prevent auto theft by authorizing the police to conduct suspicionless searches of automobile junkyards. According to Justice Blackmun, what lower courts failed to realize was that “a State can address a major social problem *both* by way of an administrative scheme *and* through penal sanctions.”⁵⁴¹ Penal laws and administrative regulations may aim toward the same “ultimate purpose” even if the regulatory goals of an administrative search are narrower.⁵⁴² The Court added that auto theft was a “serious social problem” and New York had a “substantial interest in regulating the vehicle-dismantling industry because of this problem.”⁵⁴³ On remand, the fruits of the search were used to prosecute Burger for criminal possession of stolen property.

⁵³⁹ Defendant’s Response *supra* note 451, at 21 (*italics in the original*).

⁵⁴⁰ *New York v. Burger*, 482 U.S. 691 (1987).

⁵⁴¹ *Id.* at 712.

⁵⁴² *Id.* at 713.

⁵⁴³ *Id.*

Appealing to *Burger*, supporters of drug testing might argue that a valid administrative search may have the same ultimate purpose as the penal law—namely, combating illegal drug use—even if its regulatory goals are narrower—weeding illegal drug users out of public assistance programs. Moreover, the fruits of that search can also be used in a criminal prosecution. As Justice Blackmun argued in *Burger*, a valid administrative scheme does not become unconstitutional merely because an officer discovers evidence of a crime in addition to a violation of the administrative statute itself.⁵⁴⁴ Nor is evidence garnered from that search inadmissible.

In *Ferguson*, Justice Stevens attempted to reconcile the tension between the hospital drug testing policy and *Burger* by proposing that where the individual interest in privacy is “particularly attenuated” or where the discovery of criminal evidence is “merely incidental to the purpose of the administrative search,” the search may fall within the scope of the special needs doctrine.⁵⁴⁵ Although the Supreme Court has long held that a lesser expectation of privacy attaches to commercial property and other “closely regulated industries,” in what sense was discovery of stolen auto parts in “merely incidental?” The statute authorized police officers to search junkyards for *stolen* vehicles, in an effort to combat what the *Burger* Court itself described as a “serious social problem in automobile theft.”⁵⁴⁶

The Court’s attempt to explain away the discovery of stolen auto parts as “merely incidental,” and thereby salvage the holding in *Burger*, goes to a longstanding dilemma in the special needs doctrine—in what sense must a special need lie “beyond the normal need for law enforcement?” In *Ferguson*, the Court attempted to answer that question by emphasizing that the immediate objective of the hospital drug testing policy was to generate evidence that would be

⁵⁴⁴ *Id.* at 716.

⁵⁴⁵ *Ferguson v. City of Charleston*, 532 U.S. 67, 87 n.5 (2001).

⁵⁴⁶ *New York v. Burger*, 482 U.S. 691, 731 (1987).

admissible in a subsequent criminal prosecution.⁵⁴⁷ The Court also highlighted the excessive involvement of law enforcement officers in both the creation and day-to-day administration of the policy. In contrast to *Ferguson*, there is little evidence that the “immediate objective” or “primary purpose” of imposing a drug testing requirement on public assistance is to generate evidence for a criminal proceeding. Nor is there evidence of an excessive entanglement between public assistance programs and law enforcement. To that end, courts might well conclude that the primary purpose of requiring TANF recipients to pass a drug a drug test is administrative; therefore, evidence of illegal drug use is admissible in a criminal prosecution under *Burger*.

The problem with such a holding is that it ignores the central premise of the special needs doctrine—namely, that suspicionless searches are permissible when governments confront special needs “beyond, the normal need for law enforcement.” Suppose that in an effort to better serve dual-system clients, TANF programs, child protective services and law enforcement agencies begin to work closely with one another. Suppose further that the TANF program asks one of their clients to take a drug test based in part on information obtained from child protective services and law enforcement. Both *Burger* and *Griffin* suggest that a positive test result would be admissible in court. Yet, the problem with a rule that allows information gained through a special needs search to be used in a criminal prosecution is that doing so opens a large and tempting back door for prosecutors to circumvent garden variety Fourth Amendment protections.⁵⁴⁸ Given the possibility for abuse, courts should instead adopt a prophylactic rule that would bar prosecutors from using evidence obtained through a special needs search in a criminal case.

⁵⁴⁷ *Ferguson*, 532 U.S. at 86.

⁵⁴⁸ Ordinarily a drug test requires probable cause, and as in *Griffin*, an unsubstantiated tip would fall short of probable cause for a search. See e.g. *Griffin v. Wisconsin*, 483 U.S. 868, 876 (1987).

Finally, when assessing the intrusiveness of a special needs search, courts will also ask whether sharing information with third parties violates a reasonable expectation of privacy held by TANF recipients. In *Ferguson*, Justice Stevens noted that the hospital policy involved a “far more substantial” invasion of privacy than previous special needs cases since the policy would have allowed hospital officials to disclose test result to law enforcement officials without the knowledge or consent of their patients.⁵⁴⁹ In a hospital setting the reasonable expectation of privacy held by most patients is that hospitals will not share their lab results with third parties without their consent.⁵⁵⁰ In contrast to *Ferguson*, however, Florida’s drug testing policy requires TANF applicants to acknowledge that test results collected to determine TANF eligibility will be reported to the Florida Abuse Hotline “for review to initiate an assessment or an offer of services.”⁵⁵¹ Although disclosure agreements like this one would inform TANF applicants of possible information sharing with third-parties, a typical applicant might suspect that the purpose of sharing their drug test results with the Florida Abuse Hotline is to facilitate a referral for substance abuse treatment and for their benefit only, rather than relaying information to child protective services, and certainly not to law enforcement agencies. With only minor corrections to disclosure policies, courts are likely to conclude that sharing information with third parties does not intrude upon a reasonable expectation of privacy held by most TANF recipients.

⁵⁴⁹ *Id.* at 78.

⁵⁵⁰ *Id.*

⁵⁵¹ Verified Complaint: Class Action at 37, *Lebron v. Wilkins*, 820 F. Supp. 2d 1273 (M.D. Fla. 2011) (No. 6:11-cv-01473-MSS-DAB).

ii. A PUBLIC HEALTH PERSPECTIVE

From a conventional Fourth Amendment perspective, the central questions with respect to the nature and intrusiveness of a search are whether drug testing furthers a valid non-law enforcement interest, and whether sharing test results with third parties would violate a reasonable expectation of privacy held by public assistance recipients. However, from a public health perspective, the important questions are far different. Instead, the important questions concern the impact of drug testing requirements on the health of illegal drug users and the people around them. A public health approach would keep two considerations in mind. First, regulations to protect the public's health will often involve risk-risk tradeoffs. Such tradeoffs occur when interventions designed to decrease one risk, simultaneously increase another.⁵⁵² Second, a public health perspective, particularly a population-level perspective, would consider the likely health impacts of drug testing requirements on people who use illegal drugs, as well as likely “spillover effects” on their minor children and the communities around them.

Requiring public assistance recipients to pass a drug test would decrease the risk that taxpayer dollars are used to fund illegal drug use. On the other hand, if parents are at all concerned that they might test positive for drugs, then sharing positive test results with child protective services or law enforcement could deter parents from applying for public assistance for fear that they might lose custody of their children or face incarceration. Paradoxically, by driving at-risk parents away from social services, policies designed to protect children could actually increase the risk that children who are in abusive homes will go undetected.

⁵⁵² GOSTIN, *supra* note 341, at 62.

Qualitative studies on pregnant women who use illegal drugs suggest that sharing test results with law enforcement may discourage women from seeking necessary assistance.⁵⁵³ A study by the U.S. General Accounting Office found that for drug dependent women, the fear of legal repercussions can be a potent barrier to medical care:

Drug treatment and prenatal care providers told us that the increasing fear of incarceration and losing children to foster care is discouraging pregnant women from seeking care. Women are reluctant to seek treatment if there is a possibility of punishment. They also fear that if their children are placed in foster care, they will never get their children back.⁵⁵⁴

Anticipating such problems, most states would allow parents who test positive for drugs to appoint a third party beneficiary to receive benefits on behalf of a minor child. However, parents may be reluctant to disclose their need for a third-party beneficiary to a friend or family member. According to the Florida Department of Children and Family Services, the number of TANF applications has declined since drug testing began in July 2011, suggesting both that HB 353 has had its intended deterrent effect, but also that TANF applicants who use drugs have not enrolled their children in TANF through third-party beneficiaries.⁵⁵⁵

⁵⁵³ Sarah C. M. Roberts & Cheri Pies, *Complex Calculations: How Drug Use During Pregnancy Becomes a Barrier to Care*, 15 MATERNAL & CHILD HEALTH 333 (2011); See generally Martha A. Jessup et al., *Extrinsic Barriers to Substance Abuse Treatment Among Pregnant Drug Dependent Women* 33 J. DRUG ISSUES 285 (2003); Marilyn Poland, *Punishing Pregnant Drug Users: Enhancing the Flight From Care* 31 DRUG & ALCOHOL DEPENDENCE 199 (1993).

⁵⁵⁴ U.S. GENERAL ACCOUNTING OFFICE, DRUG-EXPOSED INFANTS: A GENERATION AT RISK 9 (1990), available at <http://archive.gao.gov/d24t8/141697.pdf>.

⁵⁵⁵ Since information sharing may be associated with public health gains, states should consider a middle ground that would allow TANF programs to share test results with child welfare agencies, but prohibit those agencies from using test results in a custody hearing or a criminal prosecution. For more on the benefits of interagency collaboration see CYNTHIA ANDREWS SCARCELLA ET AL., THE URBAN INSTITUTE, COLLABORATION BETWEEN STATE AND WELFARE AGENCIES (2002), <http://www.urban.org/publications/310563.html>.

C. EFFECTIVENESS

Courts will ask whether laws that condition public assistance benefits on passing a drug test are “reasonably likely” to achieve their objectives. Although several states have passed laws that require TANF applicants to pass a drug test before they qualify for benefits, state laws differ from one another in important ways. In Florida and Georgia, state laws require all TANF applicants to pass a drug test before they qualify for assistance. In Arizona, Missouri and Utah, state laws require a reasonable suspicion of illegal drug use before TANF programs can require a drug test. Although a few states like Missouri would allow TANF applicants who test positive for drugs to retain their benefits on the condition that they participate in a substance abuse treatment program, Florida and Georgia would not.

Eventually all states would suspend assistance to someone who continues to test positive for drugs. Part II.B.c. will argue that although some suspicionless drug testing policies are likely to identify TANF recipients who use illegal drugs, policies that deny public assistance benefits to illegal drug users are unlikely to advance many of the states’ other objectives, including encouraging the transition from welfare to work, and preventing child abuse. The following section will also argue that the Supreme Court should incorporate a least intrusive alternative requirement into the special needs doctrine. Without a requirement to seek the least intrusive alternative special needs searches are needlessly overinclusive.

i. TAXPAYER SUBSIDY OF ILLEGAL DRUG USE

The Supreme Court has been of two minds about the role of effectiveness in a special needs analysis. In *Von Raab*, the Court rejected the petitioner’s contention that requiring a drug test as a condition of promotion in the Customs Service was unreasonable since employees could schedule

the date of the drug test and presumably abstain from illegal drug use in advance of the test.⁵⁵⁶ Justice Kennedy reasoned that drug addicts would be unable to abstain from drugs, even for a limited period of time, and in any event, the amount of time that it would take for a particular drug to become undetectable in the system varies widely from person to person, and that information would likely remain unknown to the employee.⁵⁵⁷ However, several years later in *Chandler*, the Supreme Court struck down suspicionless drug testing as a condition of placement on the Georgia state ballot, reasoning that Georgia's certification requirement was "not well designed to identify candidates who violate antidrug laws."⁵⁵⁸ As Justice Ginsburg remarked, drug tests scheduled by the candidate were "no secret" and the government failed to explain why ordinary law enforcement mechanisms were insufficient to identify illegal drug users "should they appear in the limelight of the public stage."⁵⁵⁹

From a public health perspective, regulations that burden individual interests in privacy are only justified when they are reasonably likely to accomplish their public health goals. However, requiring TANF applicants to pass a drug test on their initial application for benefits will fail to identify the small number of TANF applicants who do in fact use drugs. Not unlike the drug tests at issue in *Von Raab* and *Chandler*, HB 353 would require a onetime drug test as part of an initial application for TANF benefits, and as in *Chandler*, the date of a drug test to be scheduled by the TANF applicant is "no secret." States like Florida have failed to explain why most TANF applicants would be unable to abstain from illegal drug use long enough to avoid detection. Of those public

⁵⁵⁶ Nat. Treasury Employees Union v. Von Raab, 489 U.S. 656, 676 (1989).

⁵⁵⁷ *Id.*

⁵⁵⁸ *Chandler v. Miller*, 520 U.S. 305, 319 (1997).

⁵⁵⁹ *Id.* at 320.

assistance recipients who have reported illegal drug use during the past month or year, most report use of marijuana.⁵⁶⁰ Marijuana is not a highly addictive substance, and for most people, the metabolites of marijuana become undetectable through urine analysis after 10 days.⁵⁶¹ A small number of public assistance recipients have reported use of “hard drugs” like cocaine and methamphetamine.⁵⁶² Although highly addictive, the metabolites of these drugs are detectable in the system for only a few days.⁵⁶³ Most TANF applicants, save for those who are prohibitively addicted, would be able to pass a scheduled drug test.

As in *Chandler*, state statutes that would require new TANF applicants to complete a scheduled drug test are not well designed to identify applicants who have violated antidrug laws, but what about random drug testing? In *Marchwinski v. Howard*, Michigan proposed to combine an initial drug test for TANF applicants with random drug testing for current TANF recipients.⁵⁶⁴ Random drug testing would allow states to identify TANF applicants who have used illegal drugs; however as I argued above, courts are unlikely to see a state interest in ensuring that taxpayer dollars reach their intended beneficiaries as “substantial” within the meaning of *Chandler*.

⁵⁶⁰ Jaykody et al., *supra* note 464 at 637.

⁵⁶¹ Paul L. Cary, *Marijuana Detection Window: Determining the Length of Time Cannabinoids Will Remain Detectable in Urine Following Smoking: A Critical Review of Relevant Research and Cannabinoid Detection Guidance for Drug Courts*, 5 DRUG COURT REV. 23 (2005).

⁵⁶² Jayakody et al., *supra* note 464, at 638.

⁵⁶³ ENNO FREY & JOESPH V. LEVY, PHARMACOLOGY OF COCAINE, AMPHETAMINES, ECSTASY AND RELATED DESIGNER DRUGS: A COMPREHENSIVE REVIEW OF THEIR MODE OF ACTION, TREATMET OF ABUSE, AND INTOXICATION 255 (2009).

⁵⁶⁴ *Marchwinski v. Howard*, 113 F. Supp. 2d 1134 (E.D. Mich. 2000).

ii. DRUG USE AND EMPLOYMENT

Proponents of drug testing have also argued that statutes like HB 353 are designed to address government interests beyond merely identifying potential misuse of taxpayer dollars, for example—a state interest in giving people an incentive to get off drugs or encouraging the transition from welfare to work. What should we make of these claims? In 1997 Congress eliminated Supplemental Security Income (SSI) for people with a primary diagnosis of drug addiction.⁵⁶⁵ Not unlike HB 353, the purpose of eliminating SSI benefits for people with a primary diagnosis of drug addiction was to encourage substance abusers to take responsibility for their illegal drug use. And not unlike HB 353, an important purpose of the federal benefit termination was to address a public perception that providing federal disability benefits to drug addicts only enabled their illegal drug use.⁵⁶⁶ Although some former SSI beneficiaries were able to secure stable employment, many others were not.

Without employment, many former SSI beneficiaries turned to TANF and state emergency relief, resulting in cost-shifting onto states and local governments. A longitudinal study of former SSI beneficiaries found that within 2 years of benefit termination, 20 percent of former beneficiaries reported income assistance from other public programs including TANF, general assistance, and veterans' benefits.⁵⁶⁷ Another study found that after 4 years, nearly 40 percent of former SSI beneficiaries in Northern California reported TANF or general state assistance as their primary source of income.⁵⁶⁸ The same study found that former SSI beneficiaries who came to rely on

⁵⁶⁵ Carole Roan Gresenz et al., *Supplemental Security Income (SSI), Disability Insurance (DI), and Substance Abusers*, 24 CMTY. MENTAL HEALTH J. 337 (1998).

⁵⁶⁶ *Id.* 339-342.

⁵⁶⁷ James A. Swartz et al., *Termination of Supplemental Security Income Benefits for Drug Addiction and Alcoholism: Results of a Longitudinal Study of the Effects on Former Beneficiaries*, 78 SOC. SERV. REV. 96 (2004).

TANF or general assistance also reported an increase in their utilization of mental health services.⁵⁶⁹

The federal experience suggests that if states were to withhold public assistance benefits from people who fail a drug test, or from those who are unable to complete a substance abuse treatment program, the cost of these policies may be passed onto others, or felt downstream, in other parts of the social safety net.

It may be that those who were able to complete the transition from federal disability benefits to work were among the least impaired. A Chicago study found that when compared to former beneficiaries who were able to secure even marginal employment of at least \$500 a month, former disability beneficiaries who remained unemployed or underemployed were 5 times more likely to be drug dependent and 6 times more likely to be psychiatrically impaired.⁵⁷⁰ Those who were unable to secure employment were also more likely to be dependent on cocaine or heroin, and far less likely to have any means of social support save for friends, family members or possibly resorting to illegal activities.⁵⁷¹ Although states vary in the penalties attached to a positive drug test, studies like this one suggest that for those who are the most vulnerable, the most bereft of resources—and therefore most likely to contribute to the public health and crime risks associated with the drug epidemic—removing public assistance benefits without further social support is more likely to exacerbate the problem than alleviate it.

⁵⁶⁸ Sean R. Hogan et al., *The Effects of Eliminating Supplemental Security Income Drug Addiction and Alcoholism Eligibility on the Mental Health of Low-Income Substance Abusers*, 25 SOC. WORK IN PUB. HEALTH 438 (2010).

⁵⁶⁹ *Id.* at 446.

⁵⁷⁰ James A. Swartz et al. *Severe Mental Illness and Substance Use Disorders Among Former Supplemental Security Income Beneficiaries for Drug Addiction and Alcoholism*, 57 ARCHIVES GEN. PSYCHIATRY 701 (2000).

⁵⁷¹ *Id.* at 706.

A few states like Missouri have proposed a middle ground. In Florida TANF applicants who test positive for drugs are ineligible for income assistance through TANF, with no option to retain their benefits while participating in a treatment program. However, in Missouri, TANF applicants who test positive for drugs have the option to retain their benefits on the condition that they enroll in a substance abuse treatment program for six months and do not test positive for drugs while participating in the program.⁵⁷² Anyone who tests positive for drugs a second time would be TANF ineligible for three years. In Florida, TANF applicants who test positive for drugs would be ineligible for income assistance, but remain eligible for other benefits like food stamps and child care. In Missouri, however, TANF recipients who test positive for drugs a second time would lose access to *all* of their TANF benefits—temporary cash assistance, food stamps, child care, and other state programs, partially funded through TANF.⁵⁷³

Sooner or later many, if not most, people who are required to participate in a substance abuse treatment program will relapse.⁵⁷⁴ From a public health perspective, the question is whether the loss of public assistance benefits will provide an effective incentive for them to stop using illegal drugs. For some casual drug users, the possibility that they might lose their TANF benefits might be enough to stop, but for those are drug dependent, the answer is probably not. Decades of research on addiction have shown that prolonged drug use can alter the structure and function of the brain.⁵⁷⁵ When areas of the brain involved in reward, memory and inhibition are disrupted, the capacity to stopping using drugs is also disrupted, even if continued drug use means the person stands to lose

⁵⁷² MO. REV. STAT. § 208.027 (2012).

⁵⁷³ MO. REV. STAT. § 208.027 (2012).

⁵⁷⁴ A. Thomas McLellan et al., *Drug Dependence a Chronic Medical Illness*, 284 J. THE AM. MED. ASS'N. 1689 (2000).

⁵⁷⁵ NATIONAL INSTITUTE ON DRUG ABUSE, DRUGS, BRAINS, AND BEHAVIOR: THE SCIENCE OF ADDICTION (2010).

everything that he or she once valued.⁵⁷⁶ The result is that negative incentives like threatening public assistance recipients with the loss of benefits like income assistance, public housing, or unemployment programs probably won't provide an effective incentive for them to stop using drugs. There is also the further concern alluded to above—namely, that if states push drug addicts out of public assistance programs, the costs of doing so may be felt by others.

iii. CHILD ABUSE AND NEGLECT

Supporters of drug testing argue that these policies are justified by a state interest in combating drug-related child abuse and neglect. Yet, as I argued above, if parents are even remotely concerned that they might test positive for drugs, sharing test results with law enforcement could deter parents from applying for public assistance for fear that they might lose custody of their children or face incarceration. By driving at-risk parents away from social services, states could actually increase the risk that children who are in abusive homes go undetected.

However, denying public assistance benefits to parents who use illegal drugs could create additional problems for low-income children, even apart from communication with law enforcement. A study of welfare recipients in Chicago found that substantial declines in welfare income, problems with utility assistance, food shortages and eviction threats all significantly increased the risk of child welfare involvement.⁵⁷⁷ Without income assistance, most parents will lack sufficient resources to secure basic household needs, thereby putting their children at risk. As one woman in the study put it, welfare income provides her “stable money,” the money she and her

⁵⁷⁶ *Id.*

⁵⁷⁷ Kristin Shook, *Does the Loss of Welfare Income Increase the Risk of Involvement with the Child Welfare System?* 24 CHILDREN & YOUTH SERVICES REV. 693 (1999).

children rely on when a part-time job does not last for more than a few months, or when an employer cannot provide more than a few hours of work.⁵⁷⁸

Although most state proposals would allow parents who test positive for drugs to continue receiving food stamps or child care services in an effort to insulate children from the impact of welfare sanctions on their parents, these safeguards are likely to be inadequate. A 2002 study on welfare reform found that welfare sanctions resulting in a loss of income significantly increased the risk that children faced food insecurity, even when families continued to receive food stamps.⁵⁷⁹ For most people, the average monthly food stamp benefit of \$4.46 per day, \$1.48 per meal, does not provide enough money to buy healthy food.⁵⁸⁰ A large literature on nutrition has shown that micronutrient deficiencies at an early age are associated with a wide variety of adverse outcomes for children, ranging from impaired cognitive development and poor school performance to chronic disease and increased susceptibility to infection.⁵⁸¹ The result is that although states have adopted drug testing requirements largely in an attempt to sanction adults who use illegal drugs, withholding public assistance benefits from parents could inadvertently harm their children.

⁵⁷⁸ *Id.* at 698.

⁵⁷⁹ John T. Cook et al., *Welfare Reform and the Health of Young Children: A Sentinel Survey in 6 U.S. Cities*, 156 ARCHIVES GEN. PSYCHIATRY, 678 (2002); *See also* Earnestine Willis et al., *Welfare Reform and Food Insecurity*, 151 ARCHIVES PEDIATRIC & ADOLESCENT MED. 871 (1997).

⁵⁸⁰ Kaiser Family Foundation, *Average Monthly Food Stamp Benefit Per Person, FY 2011* <http://www.statehealthfacts.org/comparetable.jsp?cat=1&ind=26>. (last visited Jun. 5, 2012); *See also* Representative Barbara Lee (D-CA), Representative Joan Emerson (R-MO) & Representative Jim McGovern (D-MA), *Take the Challenge: Living on a Food Stamp Budget*, www.frac.org/pdf/FSC_Toolkit.pdf (last visited Jun. 5, 2012).

⁵⁸¹ Katherine Alaimo et al., *Food Insecurity, Family Income, and Health in U.S. Preschool and School-aged Children*, 91 AM. J. PUB. HEALTH 781 (2001).

iv. THE LEAST INTRUSIVE ALTERNATIVE

Proposals to condition public assistance benefits on passing a drug test are unlikely to achieve many of the states' objectives. However, even when policies are well designed and reasonably likely to accomplish their objectives, they may still impose unacceptable burdens on individuals' rights nonetheless.⁵⁸² In public health, the requirement to seek the least intrusive alternative instructs officials to adopt policies that achieve their objectives as well or better than possible alternatives, while imposing the fewest burdens on individual interests.⁵⁸³

Nevertheless, the Supreme Court has consistently said that the Fourth Amendment does require governments to adopt the least intrusive alternative. In *Earls*, Justice Thomas flatly asserted that a reasonable government search does not require an individualized suspicion of wrongdoing, and to that end, nor does the Fourth Amendment require governments to seek the least intrusive alternative.⁵⁸⁴ The categorical rejection of the least intrusive alternative requirement issued by the plurality in *Earls* reflects a larger and longstanding debate about the relationship between the Reasonableness Clause and the Warrant Clause of the Fourth Amendment. Justice Thomas, an adherent to the Reasonableness school of thought has long defended the position that the Warrant Clause does not inform the Reasonableness Clause; therefore, the Fourth Amendment does not require an individualized suspicion of wrongdoing.

Whatever one might think about the relationship between the Reasonableness Clause and the Warrant Clause, we can understand the requirement that the government adopt the least intrusive means of accomplishing its objectives as a fundamental element of what it means for a government search to be reasonable. If the government can accomplish its objectives as well or

⁵⁸² GOSTIN, *supra* note 341, at 68.

⁵⁸³ *Id.*, at 142.

⁵⁸⁴ *Earls*, 536 U.S., at 837.

better through means that impose fewer burdens on personal rights and freedoms, a more intrusive method would be patently unreasonable.⁵⁸⁵ Without incorporating a least intrusive alternative requirement into the special needs doctrine, government searches may be overinclusive, sweeping far more people than necessary under the ambit of regulation. In this case, since the vast majority of people who receive public assistance from the government do not use illegal drugs, requiring all of them to take a drug test would be vastly overinclusive, with little or no public health gain.

At times the Supreme Court has suggested that the problem with incorporating a less intrusive alternative requirement into the special needs doctrine is that it would be too difficult for courts to imagine less intrusive alternatives to the proposed government program. In *Earls*, Justice Thomas added that “[t]he logic of such elaborate less-restrictive-alternative arguments could raise insuperable barriers to the exercise of virtually all search-and-seizure powers.”⁵⁸⁶ Why should that be the case? Even if the Supreme Court were reluctant to incorporate the least intrusive alternative requirement into its Fourth Amendment jurisprudence generally, that fact alone should not discourage the Court from adding a least intrusive alternative requirement to the special needs doctrine. Incorporating a least intrusive alternative requirement into the special needs doctrine would not require courts to hypothesize potential less intrusive alternatives. Instead, not unlike other areas of the law in which courts engage in a least intrusive alternative analysis, governments should bear the burden to demonstrate that its objectives could not be achieved as well or better through less intrusive methods.

⁵⁸⁵ See also *Jacobson v. Massachusetts*, 197 U.S. 11, 28 (1905) (holding that while governments may impose restraints on individual liberty for the common good, the exercise of police powers must be based on the “necessity of the case,” and may not go “beyond what was reasonably required for the safety of the public.”); See also James F. Childress et al., *Public Health Ethics: Mapping the Terrain*, 30 J.L. MED & ETHICS 169, 172 (2002) (arguing that public health officials should interpret the least intrusive alternative requirement as corollary of the requirement that governments exercise coercive public health powers in response to a genuine public health necessity).

⁵⁸⁶ *Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls*, 536 U.S. 822, 837 (2002).

1. SUSPICION-BASED DRUG TESTING

In *Earls*, a plurality of the Court insisted that the Fourth Amendment does not require consideration of less intrusive alternatives. In *Chandler*, however, the Supreme Court alluded approvingly to idea that the a reasonable search under the special needs doctrine might require governments to seek the least intrusive means to accomplish their objectives. Justice Ginsburg strongly suggested that Georgia ought to explain why an appearance in the “limelight of the public stage” would not suffice to apprehend addicted candidates for public office and the failure to provide such an explanation was a constitutionally relevant consideration.⁵⁸⁷ In the same way, the *Chandler* majority contrasted the circumstances of candidates for public office—subject to relentless scrutiny by their peers, the public, and the press—to that of the customs agents at issue in *Von Raab* for whom it would not have been feasible to subject their behavior to the kind of day-to-day scrutiny that is the norm in an ordinary office environment.⁵⁸⁸ The very strong suggestion emerging from *Chandler* is that when government actors are able to detect drug related impairment without a drug test, blanket suspicionless drug tests are “not needed” and inappropriate.⁵⁸⁹

In contrast to the customs agents in *Von Raab*, welfare recipients are subject to constant scrutiny. Most states require regularly scheduled home visits as a condition of receiving welfare benefits, and regularly scheduled appointments with case managers to review eligibility for benefits and progress toward employment.⁵⁹⁰ Since each of these activities provide an opportunity for

⁵⁸⁷ *Chandler v. Miller*, 520 U.S. 305, 320 (1997).

⁵⁸⁸ *Id.* at 321.

⁵⁸⁹ *Id.* at 320.

⁵⁹⁰ U.S. DEPT OF HEALTH & HUMAN SERVICES, HHS-100-99-0003, THE APPLICATION PROCESS FOR TANF, FOOD STAMPS, MEDICAID AND SCHIP (2003).

programs to identify drug-related impairment, without subjecting all welfare recipients to a drug test, *Chandler* suggests that blanket suspicionless drug tests for all welfare recipients may be unreasonable.

Instead, most states require a reasonable suspicion of drug use before conducting a drug test. A few states require TANF applicants to complete a survey or recent drug use questionnaire.⁵⁹¹ However, since few applicants disclose illegal drug use, most states rely on case managers to recognize the signs of drug use—eyes that appear red, glazed or unable to focus, slurred speech, and poor coordination. While drug testing based on a reasonable suspicion of drug use rests on surer Fourth Amendment grounds, from a public health perspective, suspicion-based approaches are not without their problems. Although there are some classic signs of drug use, courts have at times looked favorably upon factors with questionable value—being unusually tired, or unusually active; excessive meticulousness or an unusually messy appearance; changes in behavior, even showing up late or unusually early for an activity.⁵⁹² If courts permit such a wide range of factors to create a reasonable suspicion of illegal drug use, unscrupulous case managers could easily use the pretense of reasonable suspicion of drug use to harass unpopular clients. Requiring case managers to request a drug test when they have reason to believe that their clients are using drugs could also undermine the trust between caseworker and client.

Yet, however imperfect, policies that require a reasonable suspicion of drug use are preferable to a regime of blanket suspicionless drug testing for all welfare recipients. By itself being unusually tired, or even unusually messy or disheveled does not (or should not) create a reasonable suspicion of drug use. However, when taken together with some of the indicators described above—eyes that appear glazed, or unusually fixed, poor coordination and slurred speech—certain

⁵⁹¹ Sulzberger, *supra* note 1, at A1.

⁵⁹² Martin H. Belsky, *Random vs. Suspicion-Based Drug Testing in the Public Schools—A Surprising Civil Liberties Dilemma*, 27 OKLA. CITY U. L. REV. 1, 19 (2002).

signs such as an particularly disheveled appearance and unusual sluggishness can create a reasonable suspicion of illegal drug use. Under such circumstances, we have less reason to worry about abuse. Policies that offer people who test positive for drugs the opportunity to participate in a substance abuse program can also mitigate some of the harmful effects of suspicion-based testing on the caseworker client relationship.

D. THE INDIVIDUAL INTEREST IN PRIVACY

i. A FOURTH AMENDMENT PERSPECTIVE

Finally, courts must consider the individual interest in privacy. From a conventional Fourth Amendment perspective, the central question with respect to the privacy interests of welfare recipients is whether drug testing intrudes upon a reasonable expectation of privacy. The Supreme Court has appealed to a variety of factors in order to determine whether an expectation of privacy is reasonable. At times, the Supreme Court has suggested that whether a person has a reasonable expectation of privacy depends upon his or her relationship with the state. In *Griffin* the Supreme Court held that although a probationer's home is protected by the Fourth Amendment, the supervisory relationship between the probationer and the State permits "a degree of impingement upon privacy that would not be constitutional if applied to the public at large."⁵⁹³ The Supreme Court has also said that voluntary participation in a closely regulated industry can diminish an otherwise reasonable expectation of privacy.⁵⁹⁴ Extending that logic to schoolchildren in *Vernonia* and *Earls*, the Court held that not unlike "adults who choose to participate in a 'closely regulated industry'" children who participate in extracurricular activities, voluntarily subject themselves to a

⁵⁹³ *Griffin v. Wisconsin*, 483 U.S. 868, 875 (1987).

⁵⁹⁴ *New York v. Burger*, 482 U.S. 691, 700 (1987).

greater degree of regulation than others.⁵⁹⁵ Moreover, public school children are subject to countless school rules and public health regulations, in addition to the rules governing their extracurricular activities, all of which work to diminish their expectations of privacy.⁵⁹⁶ Applying the logic of *Vernonia* and *Earls*, courts might conclude that public assistance recipients voluntarily subject themselves to a higher degree of regulation than others, and therefore enjoy a diminished expectation of privacy.

Still, arguments along these lines are vulnerable to a few objections. In both *Vernonia* and *Earls*, the Court based its decision on the custodial responsibilities of public schools when children are entrusted to their care.⁵⁹⁷ In a strongly worded conclusion, the Court limited its decision to public schoolchildren and “caution[ed] against the assumption that suspicionless drug testing will readily pass muster in other contexts.”⁵⁹⁸ Moreover, the Supreme Court’s decision in *Chandler v. Miller* casts considerable doubt on the role of voluntariness when determining individual expectations of privacy. In *Chandler*, the Supreme Court held that blanket suspicionless drug testing of all candidates for state office violated the Fourth Amendment, even though candidates seeking public office did so voluntarily. Instead, *Chandler* suggests that whether individuals have a diminished expectation of privacy depends in large part on the strength of the government interest in a search.

The Court took a similar approach in *Skinner* and *Von Raab*. In both cases, the Supreme Court asserted that an otherwise reasonable expectation of privacy can be diminished by a

⁵⁹⁵ *Vernonia v. Sch. Dist. 47J v. Acton*, 515 U.S. 646, 657 (1995); *Bd. of Educ. of Indep. Sch. Dist. No. 92 of Pottawatomie County v. Earls*, 536 U.S. 822, 831 (2002).

⁵⁹⁶ *Id.* at 656.

⁵⁹⁷ *Vernonia*, 515 U.S. at 655-56; *Earls*, 536 U.S. at 838.

⁵⁹⁸ *Vernonia*, 515 U.S. at 665.

compelling government interest in public safety. In *Skinner*, the Court concluded that the privacy expectations of railroad employees were diminished by virtue of “their participation in an industry that is heavily regulated to ensure safety,” notably, “a goal, dependent in substantial part, on the health and fitness of covered employees.”⁵⁹⁹ Likewise with respect to the customs agents at issue in *Von Raab*, that Supreme Court concluded that since “successful performance of their duties depends uniquely on their judgment and dexterity,” customs agents “cannot reasonably expect to keep from the Service personal information that bears directly on their fitness.”⁶⁰⁰

Taken together, *Chandler*, *Von Raab*, and *Skinner* suggest that what matters is whether the government has demonstrated an “important” or “substantial” interest in requiring all public assistance recipients to pass a drug test. Even if the government interests at stake are more than symbolic, the government interest in saving a few thousand in taxpayer dollars probably does not rank as substantial or important within the meaning of *Chandler*. To the extent that the government has failed to demonstrate a substantial or important interest in requiring all public assistance recipients to pass a drug test, courts should conclude that the government interest in a suspicionless drug test is not sufficiently vital to outweigh the individual interest in privacy.

ii. A PUBLIC HEALTH PERSPECTIVE

In *Katz v. United States*, the Supreme Court held that while the Fourth Amendment protects reasonable expectations of privacy, the reasonable expectations of privacy held by citizens are not the only interests the Fourth Amendment protects.⁶⁰¹ To the contrary “its protections go further,

⁵⁹⁹ *Skinner v. Railway Labor Executives' Ass'n*, 489 U.S. 602, 627 (1989).

⁶⁰⁰ *Nat'l Treasury Employees Union v. Von Raab*, 489 U.S. 656, 672 (1989).

⁶⁰¹ *Katz v. United States*, 389 U.S. 347 (1967).

and often have nothing to do with privacy at all.”⁶⁰² At times the Court has instead underscored the dignity and liberty interests implicated by a blanket search. Famously remarking upon prohibition era laws aimed at concealed transportation of liquor in *Carroll v. United States*, Chief Justice Taft added: “it would be intolerable and unreasonable” if a prohibition agent were authorized to stop every automobile on the highway, “and thus subject all persons to the inconvenience and indignity of a search.”⁶⁰³

In the same way, embracing a public health perspective would lead courts toward a broader understanding of Fourth Amendment values. As Scott Burris and Ichiro Kwachi have argued, law may be a powerful social determinant of health.⁶⁰⁴ Burris and Kwachi posit two relationships between law and public health. First, the law may play a role in creating and maintaining the social structures that influence population health such as adequate housing, workplace safety, income inequality and stable employment.⁶⁰⁵ The law might also act as a pathway along which social determinants impact population health. Drawing from the literature on procedural justice, Burris and Kwachi argue that encounters with the law can be a “powerful psychosocial experience” through which “low socioeconomic status is reinforced and driven home.”⁶⁰⁶

Ethnographic studies on welfare point toward similar conclusions. Describing her experience with a local welfare office, one woman in Appalachian Ohio put it this way:

⁶⁰² *Id.* at 350.

⁶⁰³ 267 U.S. 132, 153-53 (1925).

⁶⁰⁴ Scott Burris, et al., *Integrating Law and Social epidemiology*, 30 J. LAW, MEDICINE & ETHICS 510 (2002).

⁶⁰⁵ *Id.* at 511.

⁶⁰⁶ *Id.* at 513.

Well, I feel cheap when I walk in there. I feel that everybody's looking at me and like she ain't got no job, she's dirty, and I just feel worse when I go in there and come out than I did going in there.

Another added:

They act like they own us. [Researcher:] How does that make you feel? It makes me feel real low.⁶⁰⁷

It may be that encounters like this one have implications for our health. In a well-known study of British civil servants, Michael Marmot found that lower positions in the occupational hierarchy were associated with greater risk for coronary heart disease.⁶⁰⁸ Differences in access to health care could not explain the social gradient in health since all of the civil servants who participated in the study had universal access to health care. The study also found that risk factors such as smoking, high blood pressure, and high cholesterol levels accounted for less than one third of the gradient in mortality due to coronary heart disease.⁶⁰⁹ Instead, researchers believe that low social status and low control at work, common among employees who occupy lower rungs of the occupational hierarchy, could explain their greater risk for coronary heart disease.⁶¹⁰

Further research supports the hypothesis that low social status can affect our health through the impact of stress on the cardiovascular system and the immune system. Repeated exposure to stressful events or failure to shut off the stress response efficiently can create wear and tear on the body, contributing to what social epidemiologists refer to as “allostatic load.”⁶¹¹ Overtime the

⁶⁰⁷ JOHN GILLIOM, *OVERSEERS OF THE POOR* (2001).

⁶⁰⁸ Michael G. Marmot, *Status Syndrome: A Challenge to Medicine*, 295 J. AM. MED. ASS'N 1304 (2006); *See also* Harry Hemingway et al., *Does Autonomic Function Link Social Position to Coronary Risk? The Whitehall II Study*, 111 CIRCULATION 3071 (2005).

⁶⁰⁹ *Id.* at 1305.

⁶¹⁰ *Id.*

cumulative burden of daily stressors can wear down the cardiovascular and immune systems, leading to diabetes, obesity, hypertension and greater susceptibility to infection.⁶¹²

What might these findings imply for the Fourth Amendment? What might they imply for the special needs doctrine? From a public health perspective, the Fourth Amendment protects more than our interests in privacy. By shielding us from the indignities of a government search, the Fourth Amendment protects our health.⁶¹³ The literature on social epidemiology suggests that the harms associated with suspicionless drug testing include more than the fleeting embarrassment of providing a urine sample while a lab technician “listens for the normal sounds of urination,” and inspects the sample for tampering. Instead the problem may be the way in which degrading treatment “gets under the skin.”⁶¹⁴

IV. THE UNCONSTITUTIONAL CONDITIONS DOCTRINE

Proposals to condition public assistance benefits on passing a drug test raise a Fourth Amendment question and courts are likely to analyze these statutes under the special needs doctrine. However, as a conditional benefit, these policies also implicate the unconstitutional conditions doctrine, and in doing so unearth a longstanding puzzle in constitutional law. Although neither the states nor the federal government are under an obligation to provide public assistance benefits, may

⁶¹¹ Bruce S. McEwen & Teresa Seeman, *Protective and Damaging Effects of Mediators of Stress: Elaborating and Testing the Concepts of Allostasis and Allostatic Load*, 896 ANNALS NEW YORK ACADEMY ARTS & SCI. 30 (1999).

⁶¹² Burris et al., *supra* note 604, at 513.

⁶¹³ See also Norman Daniels, Bruce P. Kennedy & Ichiro Kawachi, *Why Justice Is Good for Our Health: The Social Determinants of Health Inequalities*, 128 DAEDALUS 215 (1999) (advancing a parallel argument in the literature on public health and ethics).

⁶¹⁴ Burris et al., *supra* note 604, at 513.

the government provide public assistance on the condition that the recipient waive or surrender a constitutional right? Notwithstanding the power of government to withhold valuable benefits absolutely, the Supreme Court has limited the power of governments to provide benefits conditionally. To that end, the unconstitutional conditions doctrine limits the power of government to condition benefits on the waiver of a constitutional right.

The unconstitutional conditions doctrine emerged in the nineteenth century through a series of cases on incorporation. By the late 1950s, the Court turned its attention to individual rights. Part IV.A. provides an overview of seminal decisions in which the Supreme Court has considered the implications of the unconstitutional conditions doctrine for public assistance benefits and individual rights. Section IV.B. applies the unconstitutional conditions doctrine to drug testing and public assistance, with special attention to how the Fourth Amendment prohibition against unreasonable searches and seizures might complicate the unconstitutional conditions problem.

A. UNCONSTITUTIONAL CONDITIONS CASES

i. CONDITIONS OVERTURNED

The Supreme Court applied the unconstitutional conditions doctrine to individual rights for the first time in *Speiser v. Randall*.⁶¹⁵ In *Speiser*, the Supreme Court struck down a California statute that required WWII veterans to swear loyalty to the state as a condition of receiving a tax exemption. In an opinion by Justice Brennan, the Court held that denying a tax exemption to veterans who refused to sign a loyalty oath would in effect “penalize” the claimants for engaging in proscribed speech, or “coerce” them into refraining from disloyal speech.⁶¹⁶ To Brennan, the

⁶¹⁵ 357 U.S. 513 (1958).

⁶¹⁶ *Id.* at 518-19.

deterrent effect of the denial was no different than if the state were to issue a “fine” against proscribed speech.⁶¹⁷

In *Sherbert v. Verner*, the Supreme Court held that South Carolina could not deny unemployment benefits to a woman who refused to work on Saturday, the Sabbath Day of her faith, without burdening her interest in free exercise and violating the First Amendment.⁶¹⁸ The Court conceded that the pressure on Mrs. Sherbert was at best indirect. No criminal statute compelled Mrs. Sherbert to work on Saturdays. However, as Justice Brennan wrote: “if the purpose or effect of a law is to impede the observance...of religion,” then “that law is constitutionally invalid even though the burden may be characterized as being only indirect.”⁶¹⁹ In doing so, the Court began to answer a question left unanswered in *Speiser*, namely—how can a condition that we are free to accept or reject actually “burden” or “impinge upon” protected First Amendment interests?

In *Sherbert*, the Court alluded to three justifications for a more searching review. First, the pressure on Mrs. Sherbert to forgo the practice of her religion was “unmistakable.”⁶²⁰ By conditioning unemployment benefits on acceptance of Saturday work, South Carolina presented Mrs. Sherbert with an impossible choice—follow the basic precepts of her religion and forego benefits on the one hand, or accept work and violate her religious beliefs on the other.⁶²¹ Second, the conditional denial “threatened to produce a result which the State could not command

⁶¹⁷ *Id.* at 518

⁶¹⁸ 374 U.S. 398 (1963).

⁶¹⁹ *Id.* at 404.

⁶²⁰ *Id.*

⁶²¹ *Id.*

directly.”⁶²² Third, forcing Mrs. Sherbert to choose between her religion and unemployment benefits, “puts the same kind of burden upon the free exercise of her religion as would a fine imposed against appellant for Saturday worship.”⁶²³ Even though criminal law did not require Mrs. Sherbert to accept Saturday work, the coercive and deterrent effects were such that the Court would require South Carolina to come forward with a compelling state interest to justify the burden on free exercise. In its defense South Carolina argued that the statute was justified by a state interest in deterring fraudulent religious claims. The Court found no evidence of fraud, and more importantly, even if there had been fraud, South Carolina failed to demonstrate that less restrictive means could not have achieved the government’s objectives.⁶²⁴

Several years later the Court turned directly to public assistance benefits in *Shapiro v. Thompson*.⁶²⁵ In *Shapiro*, the Court struck down state statutes, as well as a statutory provision in the District of Columbia, that denied welfare benefits to residents who had not resided in their state or district for at least one year immediately preceding their application for welfare. The Court, per Justice Brennan, held that the statute created an invidious distinction between residents who had resided within the district for a year or more, and those who had been there for less than a year. He added: “On the basis of this sole difference the first class is granted and the second class is denied welfare aid upon which may depend the ability of families to obtain the very means to subsist—food, shelter, and other necessities of life.”⁶²⁶ The District of Columbia asserted a compelling state

⁶²² *Id.* at 405.

⁶²³ *Id.*

⁶²⁴ *Id.* at 407.

⁶²⁵ 394 U.S. 618 (1969).

interest in preserving the fiscal integrity of public assistance programs as well as administrative interests in budget planning and minimizing the risk of fraud.⁶²⁷ However, the *Shapiro* Court rejected both claims, and paid little if any attention to the alleged administrative interests. Even if the state had acted on a compelling governmental interest in minimizing fraud, the Supreme Court held that there were “less drastic means” available to minimize the risk.⁶²⁸

In *Memorial Hospital v. Maricopa County*, the Supreme Court also struck down an Arizona statute that conditioned nonemergency medical assistance at the county expense on residence within the state for at least the preceding 12 months.⁶²⁹ In an opinion by Justice Marshall, the Court clarified the deterrence and penalty rationales in *Shapiro*. Although the Court would consider whether a durational residence requirement deterred the right to travel, proof of actual deterrence was unnecessary.⁶³⁰ Instead a residence requirement would trigger the *Shapiro* compelling interest test if it includes “any classification which serves to *penalize* the exercise of the right [to travel].”⁶³¹ The Court took *Shapiro* to stand for the proposition that a “denial of the ‘basic necessities of life’” constitutes a penalty on the right to travel. To Justice Marshall, medical care was as much a basic necessity of life as welfare.⁶³²

⁶²⁶ *Id.* at 627.

⁶²⁷ *Id.* at 634-636.

⁶²⁸ *Id.* at 637.

⁶²⁹ 415 U.S. 250 (1974).

⁶³⁰ *Id.* at 257.

⁶³¹ *Id.* at 258.

⁶³² *Id.* at 259.

Like *Speiser* and *Sherbert* before it, in *Memorial Hospital* the Court left the term “penalty” undefined, and instead hinted at when a condition might rise to the level of a penalty. First, Justice Marshall distinguished the “basic necessities of life” at issue in *Shapiro* from other instances in which the Court has upheld a one year in-state residence requirement as condition of receiving lower in-state tuition. In doing so, Marshall suggested that the essential nature of medical care contributed to the willingness of the Court to characterize its denial as a penalty.⁶³³ Importantly, Justice Marshall added: “[w]hatever the ultimate parameters of the Shapiro penalty analysis....governmental privileges and benefits necessary to basic sustenance have often been viewed as being of greater constitutional significance than less essential forms of governmental entitlements.”⁶³⁴ In other words, whether or not a condition that would deny nonemergency medical care constituted a “penalty” within the meaning of *Shapiro*, the fact medical care is a basic necessity has been reason enough for courts to review a potential denial with heightened scrutiny.

i. CONDITIONS UPHELD

In *Sherbert* and its progeny, as well as *Shapiro* and *Memorial Hospital*, the Supreme Court struck down the offending statute on the ground that it penalized or deterred the exercise of a fundamental right. In the abortion funding cases—*Maher v. Roe* and *Harris v. McRae*—the Court seemed to move away from the penalty rationale. In *Maher*, the Supreme Court held that equal protection does not obligate states to pay for nontherapeutic abortions simply because they elect to pay for the expenses associated with childbirth.⁶³⁵ In *Harris*, the Court held that the federal government is not required to pay for medically necessary abortions, even though it funds other medically necessary services,

⁶³³ *Id.* at 260.

⁶³⁴ *Id.* at 285.

⁶³⁵ 432 U.S. 464 (1977).

including childbirth.⁶³⁶ In both cases, the Court reasoned that “[a] refusal to fund protected activity without more cannot be equated with the imposition of a ‘penalty’ on that activity.”⁶³⁷

Several years later, in *Lyng v International Union*, the Court upheld an amendment to the Food Stamp Act that prevented households from becoming eligible for food stamps if members of the household were on strike.⁶³⁸ The Court thought it “exceedingly unlikely” that any more than a few workers might leave their families or their unions in order to increase the amount of food going to their households.⁶³⁹ Even if the Amendment had pressured the associational rights of at least some strikers, the Constitution does not provide an entitlement to funds that might be necessary to realize the exercise of those rights.⁶⁴⁰

In *Dandridge v. Williams*, the Supreme Court also upheld a Maryland statute that limited the absolute dollar amount AFDC families could receive to no more than \$250 per family, per month, regardless of family size or need.⁶⁴¹ Where *Shapiro* and *Memorial Hospital* implicated a fundamental right to travel, the AFDC limitation implicated no such right, and the Court held that the statute was rationally supportable on any number of grounds, among them—a state interest in promoting gainful employment and family planning; a state interest in allocating public funds to as many families as possible; and a state interest in maintaining some degree of equity between welfare

⁶³⁶ 448 U.S. 297 (1980).

⁶³⁷ *Id.* at 317, n.19; *See also Maher*, 432 U.S. at 476 n.8, (rejecting the argument that “[Connecticut] ‘penalizes’ the woman’s decision to have an abortion by refusing to pay for it.”)

⁶³⁸ 485 U.S. 360 (1988).

⁶³⁹ *Id.* at 365.

⁶⁴⁰ *Id.* at 369.

⁶⁴¹ 397 U.S. 471 (1970).

recipients and wage earners.⁶⁴² Through Justice Stewart the Court acknowledged “the dramatically real factual difference” between the impoverished circumstances of persons seeking public assistance and other instances in which the Court applied rational basis review, but found no reason to apply a more rigorous standard.⁶⁴³

Finally, in *Wyman v. James* the Supreme Court upheld a New York statute that authorized home visits by an AFDC caseworker on the theory that home visits were not searches within the meaning of the Fourth Amendment, and even if they were, home visits were not unreasonable.⁶⁴⁴ The Supreme Court also touched upon the unconstitutional conditions problem that arises when governments condition public assistance benefits on the surrender of a Fourth Amendment right. In a sharply worded opinion, Justice Blackmun argued that Mrs. James certainly had a “right” to refuse home visits, but doing so would simply result in a termination of benefits, and “nothing of a constitutional magnitude” was involved.⁶⁴⁵ If anything, to the *Wyman* majority, Mrs. James was the one who appeared to be unreasonable:

What Mrs. James appears to want from the agency that provides her and her infant son with the necessities of life is the right to receive those necessities upon her own informational terms, to utilize the Fourth Amendment as a wedge for imposing those terms and to avoid questions of any kind.”⁶⁴⁶

To Justice Blackmun and members of the majority, the circumstances confronting Mrs. James were analogous to that of a taxpayer who refuses to furnish proof of a deduction. The taxpayer would be

⁶⁴² *Id.* at 483-84.

⁶⁴³ *Id.* at 485. Nor did the *Dandridge* majority pause to consider *Memorial Hospital* where the Court indicated that conditions resulting in a denial of the basic necessities of life require strict scrutiny under the Equal Protection Clause.

⁶⁴⁴ 400 U.S. 309 (1971).

⁶⁴⁵ *Id.* at 324.

⁶⁴⁶ *Id.* at 321.

fully within his “right” not to produce proof, but doing so would result in “a detriment of the taxpayer’s own making.”⁶⁴⁷

B. DRUG TESTING AND UNCONSTITUTIONAL CONDITIONS

The unconstitutional conditions doctrine limits the power of government to condition benefits on the waiver of a constitutional right. When analyzing unconstitutional conditions claims, courts will usually begin by asking whether the condition “burdens” or “impinges upon” protected interests. If so, courts will require the government to demonstrate that the regulation is narrowly tailored to a compelling governmental interest. If not, courts will sustain the regulation with evidence of a rational relationship between means and ends. Before addressing those questions however, the Fourth Amendment may present a unique set of concerns. Unconstitutional conditions problems arise when governments attempt to condition benefits on the waiver of a constitutional right. What might that imply for the Fourth Amendment prohibition against unreasonable searches and seizures? Must a plaintiff alleging a violation of the unconstitutional conditions doctrine first establish that her Fourth Amendment rights have been violated before courts will proceed and consider her unconstitutional conditions claim?

In *Sanchez v. San Diego County*, the Ninth Circuit considered and promptly rejected an unconstitutional conditions challenge to a government regulation that required welfare recipients to submit to a home “walk through” as a condition of participation in a county welfare program.⁶⁴⁸ Having established that home visits were reasonable, the Ninth Circuit found that the plaintiffs could not prevail on their unconstitutional conditions claim, since the Fourth Amendment only

⁶⁴⁷ *Id.* at 324.

⁶⁴⁸ 464 F.3d 916 (9th Cir. 2007).

prohibits unreasonable searches and seizures.⁶⁴⁹ The difference between the Ninth Circuit approach on the one hand and the plaintiff's position on the other raises a hard question about how we should view Fourth Amendment rights for the purposes of an unconstitutional conditions analysis. Should we begin with plaintiff's Fourth Amendment rights *ex ante*, viewing the government as proposing to trade some part of those rights for valued benefits? Or should we consider the scope of the plaintiff's rights *ex post*, viewed in relationship to a particular government program?

Consider Luis Lebron. Like anyone else Mr. Lebron has a Fourth Amendment right to refuse unreasonable searches and seizures. Before Mr. Lebron walks into a Florida TANF office and signs on the dotted line, his bundle of Fourth Amendment rights includes the right to refuse a suspicionless drug test. In order to determine the reasonableness of a government search, courts will weigh competing governmental and individual interests. Absent an extraordinarily compelling or weighty government interest—I have in mind something like an extraordinary public health threat—Florida could not order *all* Floridians to submit to a drug test, including Mr. Lebron. Nor, under garden-variety circumstances could Florida criminalize the failure to submit to a drug test. The result is that *ex ante* TANF applicants have a Fourth Amendment right to refuse a drug test and statutes like HB 353 in Florida offer them an opportunity to exchange some part of that right for public assistance benefits.

The same was true in *Speiser*. The First Amendment prohibits the State of California from abridging freedom of speech. The result is that WWII veterans have a First Amendment right to engage in disloyal speech. Why? With very few exceptions, the government does not have a compelling interest in imposing prior restraints on speech. In *Speiser*, California offered veterans an opportunity to exchange their First Amendment right to engage in disloyal speech for a tax exemption. Had the Supreme Court adopted the Ninth Circuit approach in *Speiser*, Justice Brennan

⁶⁴⁹ *Id.* at 930-31.

would have required WWII veterans to demonstrate that they have a First Amendment right to engage in disloyal speech *and* receive a tax exemption, before addressing the unconstitutional conditions problem.

Ordinarily however, the Court considers the scope of the plaintiff's rights *ex ante*, without reference to the particular government program in question. In *Sherbert*, the Court began by describing the scope of Mrs. Sherbert's First Amendment interest in free exercise. Justice Brennan explained that while the Court had rejected challenges to regulation of religious conduct when that conduct posed a substantial threat to public safety, Mrs. Sherbert's First Amendment objection to Saturday work fell beyond the reach of government regulation.⁶⁵⁰ Bearing the scope of Mrs. Sherbert's First Amendment interest in mind—truncated only by the prior balance of government and individual interests—the Court then considered whether disqualifying Mrs. Sherbert for unemployment benefits imposed a burden on her interest in free exercise. Concluding that it did, the Court then asked whether the regulation was narrowly tailored to a compelling governmental interest.⁶⁵¹

If courts were to adopt the approach taken by the Ninth Circuit in *Sanchez*, doing so would mean that courts will inevitably prune the of scope of Fourth Amendment protection twice—once since the plaintiff's *ex ante* bundle of Fourth Amendment rights is not absolute (like Mrs. Sherbert, Mr. Lebron's *ex ante* bundle of Fourth Amendment rights has already been limited by case law); and a second time, when courts balance the plaintiff's residual Fourth Amendment interests in privacy against the government interest in a suspicionless search, all before reaching the unconstitutional conditions problem, if at all.

⁶⁵⁰ *Speiser v. Randall*, 357 U.S. 513, 527 (1958).

⁶⁵¹ *Id.* at 529.

The approach taken in *Sanchez* is also inconsistent with the function of the unconstitutional conditions doctrine. Although we commonly refer to “unconstitutional conditions claims,” the unconstitutional conditions doctrine is not itself a legal claim that can be addressed on its own once the underlying First or Fourth Amendment questions have been resolved. Instead, the unconstitutional conditions doctrine changes the level of review attached to a First or Fourth Amendment claim, permitting courts to review conditional benefits under heightened or strict scrutiny when they would otherwise receive only deferential or passing review. Given the function of the unconstitutional conditions doctrine, courts should not require plaintiffs to establish that a constitutional right has been violated, before addressing the unconstitutional conditions problem.

Courts should instead ask whether the government program in question burdens or impinges upon the plaintiff’s *ex ante* bundle of Fourth Amendment rights. However, even if there is a viable Fourth Amendment right in play, determining the existence of that right only marks the beginning of an inquiry into the unconstitutional conditions problem. The important question is this—would requiring public assistance recipients to pass a drug test, without individualized suspicion of drug use, unduly “burden” or “impinge upon” their Fourth Amendment interests in privacy?

Despite the importance of these questions, the principle tools the Court relies upon to answer them are hopelessly indeterminate. Following the logic of *Speiser*, *Sherbert*, and *Shapiro* would lead courts to ask whether policies that condition public assistance benefits on passing a drug test are best understood as a “penalty” on claimants for exercising their Fourth Amendment rights, or better understood as a mere “non-subsidy” of Fourth Amendment rights. On the one hand, courts could easily conclude that these conditions amount to no more than a mere non-subsidy. Even if claimants have a Fourth Amendment right to refuse a drug test, *Maher* and *Harris* stand for the proposition that “without more,” refusal to fund a protected activity cannot be equated with the

imposition of a “penalty” on that activity. Following *Lyng* and *Dandridge*, courts may conclude that while claimants certainly have a Fourth Amendment right to refuse a drug test, the Constitution does not obligate governments to subsidize the exercise of that right. Nor does the Constitution shield claimants from the resulting economic hardship. On the other hand *Lyng* and *Dandridge* rest uncomfortably with *Shapiro* and *Memorial Hospital*, where the Court affirmed that the denial of a “basic necessity of life” can be tantamount to the imposition a penalty on the exercise of a fundamental right.

In *Maier* and *Harris* the Supreme Court concluded that the mere refusal to fund a protected activity cannot be equated the imposition of a penalty on that activity. Yet, in both cases, the Court recognized that a distinct constitutional question would arise if governments were to condition public assistance on the surrender of a constitutional right. In *Maier*, Justice Powell emphasized that Connecticut merely limited Medicaid payments to medically necessary abortions, leaving indigent women free to exercise their right to abortion using private funds. In dicta he indicated that had Connecticut denied welfare benefits to otherwise eligible women merely because they exercised their right to an abortion, the circumstances would have been very different—and analogous to the facts of *Shapiro*, under which a penalty analysis might have been appropriate.⁶⁵² Likewise in *Harris*, Justice Stewart concluded that states are not obligated to fund medically necessary abortions, but added: “[a] substantial constitutional question would arise if Congress had attempted to withhold all Medicaid benefits from an otherwise eligible candidate simply because that candidate had exercised her constitutionally protected freedom to terminate her pregnancy.”⁶⁵³ Importantly, Justice Stewart indicated that the latter would be analogous to *Sherbert*, where the Court held that a state may not

⁶⁵² 432 U.S. 464, 474 n.8 (1977).

⁶⁵³ 448 U.S. 297, 317 n.19 (1980).

withhold unemployment benefits from a claimant who would otherwise be eligible for benefits “but for” the fact that she is unwilling to work on her Sabbath.

In both cases, the Court indicated that the conclusions reached in *Mahe* and *Harris* might not apply when governments condition benefits on the surrender of a constitutional right. The Hyde Amendment did not require Medicaid recipients to waive their right to an abortion, and to that end, courts might reasonably conclude that the circumstances of *Lebron* bear a closer resemblance to *Sherbert* or *Speiser*. In *Speiser*, the Supreme Court held that withholding tax exemptions from WWII veterans who refuse to waive their First Amendment right to engage in disloyal speech would be no different than imposing a fine on that speech. In the same way, courts may conclude that denying public assistance benefits to someone who asserted their Fourth Amendment right not to take a drug test is no different than imposing a fine on that conduct. As in *Sherbert* and *Speiser*, concluding that the condition is no different than fine would not be enough to invalidate the statute, but it would be enough to trigger strict scrutiny.

CONCLUSION

However popular, policies that require applicants for public assistance to pass a suspicionless drug test are probably unconstitutional. Without a genuine threat to public health or public safety, states cannot meet their burden to establish a special need. I have argued that a public health approach can guide a special needs analysis under the Fourth Amendment. One might respond that such “policy approaches” fall beyond the scope of constitutional interpretation, and threaten to return the Supreme Court to a time when judges struck down statutes merely because they were “unwise, improvident or out of harmony with a particular school of thought.”⁶⁵⁴ Yet, the Supreme

⁶⁵⁴ *Dandridge v. Williams*, 397 U.S. 471, 484 (1970).

Court itself has said that a reasonable suspicionless search must address a genuine threat to public safety. To that end, the unequivocal direction of the Supreme Court in *Chandler* supports the value of a public health perspective. Proposals to condition public assistance benefits on passing a drug test also run afoul of the unconstitutional conditions doctrine.

I have also argued that withholding public assistance benefits from illegal drug users could make many social problems much worse. We know that public assistance programs like TANF provide a valuable opportunity to identify people with substance abuse problems and get them into treatment. A 2006 study on women and substance abuse found that low-income women who used illegal drugs and continued to receive cash assistance through TANF were more than twice as likely to receive substance abuse treatment when compared to low-income women who also used illegal drugs but did not receive cash assistance.⁶⁵⁵ Decades of research on addiction also point toward harm reduction methods as the approach most likely to lead to lasting reductions in drug use.⁶⁵⁶

Finally, for most low-income women who receive public assistance, child care concerns, transportation problems, poor academic skills, and language barriers are perhaps more common and present more important obstacles to full-time employment than illegal drug use.⁶⁵⁷ Despite our current focus on substance abuse and welfare, given the real problems facing low-income families, states must look elsewhere.

⁶⁵⁵ Harold A. Pollack & Peter Reuter, *Welfare Receipt and Substance Abuse Treatment Among Low-Income Mothers: The Impact of Welfare Reform*, 96 AM. J. OF PUB. HEALTH 2024 (2006). It may be that programs like TANF provide an important source of funding for treatment. See e.g. CENTER FOR BEHAVIORAL STATISTICS & QUALITY, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN, HHS No. (SMA) 11-4658, RESULTS FROM THE 2010 NATIONAL SURVEY ON DRUG USE & HEALTH: SUMMARY OF NATIONAL FINDINGS (2011) (among those who reported substance abuse treatment at a specialized facility during the past year 29.2 percent reported using their Medicaid benefits, but 35.6 percent reported using public assistance other than Medicaid).

⁶⁵⁶ Jason Kilmer et al., *Reducing Harm Associated with Illicit Drug Use: Opiates, Amphetamines, Cocaine, Steroids and Other Substances in HARM REDUCTION PRAGMATIC STRATEGIES FOR MANAGING HIGH RISK BEHAVIORS* 212 (G. Alan Marlatt et al., eds., 2nd ed. 2012).

⁶⁵⁷ Lisa R. Metsch & Harold A. Pollack, *Welfare Reform and Substance Abuse*, 83 MILLBANK Q. 65, 71 (2005).

APPENDIX 1

AOT HEARING INSTRUMENT

1. Hearing #: _____ 2. Hearing Date: ____/ ____/ ____ 3. Time: _____
4. County: _____ 5. Location _____ 6. Judge _____
- Hospital (1) _____
- Courthouse (2) _____

Respondent

- | | | | |
|---------------------------|------------------|-------------------------------|------------------------|
| 7. Race/ Ethnicity | 8. Gender | 9. Respondent does not | 10. Res. waives |
| Black (0) _____ | Male (0) _____ | contest AOT | right to appear |
| Latino (1) _____ | Female (1) _____ | No contest (0) _____ | No (0) _____ |
| White (2) _____ | | Contest (1) _____ | Yes (1) _____ |
| Asian (3) _____ | | | |
| Other (4) _____ | | | |

PETITIONER

11. Petitioner:

- | | |
|---|---|
| ____ (1) person with whom respondent resides | ____ (5) treating or supervising psychiatrist |
| ____ (2) parent/ spouse/ sibling | ____ (6) treating psychologist |
| ____ (3) hospital director | ____ (7) director of community services |
| ____ (4) director of any agency (other than hospital) | ____ (8) parole or probation officer |
| providing services to respondent | ____ (9) other |

12. Hospital Discharge ?

- ____ (0) No
- ____ (1) Yes

13. Initial or Renewal?

- ____ (1) Initial
- ____ (2) Renewal

14. Current AOT request?

APPENDIX 1

[Continued]

15. Diagnosis:

- ☐ (A) Schizophrenia
- ☐ (B) Schizoaffective Disorder
- ☐ (C) Substance Abuse Disorder
- ☐ (D) Bipolar Disorder
- ☐ (E) Depression
- ☐ (F) Not specified
- ☐ (G) Other

16. Unlikely to survive safely in community b/c:

- ☐ (1) Medication noncompliant
- ☐ (2) Lacks stable residence
- ☐ (3) History of homelessness
- ☐ (4) History of multiple hospitalizations
- ☐ (5) Poor self care (eat/dress/clean)
- ☐ (6) Other: _____
- ☐ (7) Not specified

17. Petitioning for AOT based on **two or more hospitalizations or instances of service in a correctional setting in the last 36 months?**

- ☐ (0) No
- ☐ (1) Yes
- ☐ (2) N/A Renewal

17a. If yes, how many hospitalizations or instances of service? _____

17b. Dates

APPENDIX 1

[Continued]

Episode 1: _____

Episode 3: _____

Episode 2: _____

Episode 4: _____

18. Petitioning for AOT based on **one or more acts of serious violent behavior** toward self or others, or threats of, or attempts at, serious physical harm to self or others within the last 48 months?

___ (0) No

___ (1) Yes

___ (2) N/A Renewal

Episode 1:

18a. Date of harm, threat or attempt

____/____/____

18b. Nature of Harm

___ (1) Physical harm to self

___ (6) Threat to self and others

___ (2) Physical harm to others

___ (7) Threat to self with no action

___ (3) Physical harm to self and others

___ (8) Threat to others with no action

___ (4) Physical harm to animal

___ (9) Threat to self and others with no action

___ (5) Threat to self with action

___ (10) Other: _____

APPENDIX 1

[Continued]

19. Respondent is **unlikely to participate voluntarily** as a result of mental illness

- ___ (0) does not mention
- ___ (1) nature of diagnosis
- ___ (2) failed to participate voluntarily in past
- ___ (3) other _____

20. Respondent needs AOT to **prevent relapse or deterioration** which would be likely to result in serious harm to self or others

- ___ (0) does not mention
- ___ (1) relapse has led to harm to self or others in the past
- ___ (2) Other _____

21. Respondent is **likely to benefit** from AOT

- ___ (0) does not mention
- ___ (1) has benefited from treatment in the past
- ___ (2) other _____

22. AOT is the **least restrictive alternative**

- ___ (0) does not mention

APPENDIX 1
[Continued]

___ (1) respondent has not complied with voluntary treatment in the past

___ (2) other _____

23. Other arguments in favor of petition:

24. Treatment Plan

- ___ (0) does not mention
- ___ (1) medication
- ___ (2) supervised housing
- ___ (3) ACT team
- ___ (4) individual therapy
- ___ (5) group therapy
- ___ (6) substance abuse treatment
- ___ (7) toxicology screen
- ___ (8) Other _____

RESPONDENT

28. Respondent objections?

___ No (0)

___ Yes (1)

Objection 1	_____	O/S	Objection 2	_____	O/S
Objection 3	_____	O/S	Objection 4	_____	O/S

APPENDIX 1

[Continued]

15. Does attorney for respondent cross examine examining psychiatrist?

☐ No (0)

☐ Yes (1)

☐ N/A no psychiatric testimony (2)

16. Challenge criteria for AOT?

☐ (0) No

☐ (1) Mental illness

☐ (2) Unlikely to survive safely in the community

☐ (3) Noncompliance was significant factor

resulting in hospitalization

☐ (4) Noncompliance was a significant factor

resulting in one or more serious acts of violence

☐ (5) unlikely to participate voluntarily in outpatient treatment

☐ (6) needs AOT to prevent relapse or deterioration which would

be likely to result in serious harm to self or others

☐ (7) respondent is likely to benefit from AOT

☐ (8) AOT is the least restrictive alternative

17. Argue for other less restrictive alternatives?

☐ No (0)

☐ Yes (1)

18. Other arguments against granting petition:

APPENDIX 1
[Continued]

JUDGE

19. Decision

___ (0) deny

___ (1) grant

20. Stated basis for decision?

___ (0) not stated

___ (1) stated

21. Points of emphasis:

___ (1) mental illness (severity of)

___ (2) unlikely to survive safely in the community

___ (3) noncompliance has resulted repeated hospitalization in the past

___ (4) noncompliance has been a significant factor resulting in one or more serious acts of
violence toward self or others

___ (5) respondent is unlikely to participate in outpatient treatment voluntarily

___ (6) respondent needs AOT to prevent relapse which would be likely to result in serious harm
to self or others

___ (7) respondent is likely to benefit from AOT

APPENDIX 2

ATTORNEYS INTERVIEW INSTRUMENT

Date: ____/____/____ (MM/DD/YY)

County: _____

Attorney Interview #: _____

Interviewer: The purpose of this study is to learn more about AOT hearings. This interview is completely confidential. I will not use your name in any writings, discussions or lectures produced based on this material. This interview is expected to take approximately 30 to 45 minutes. If you decide you want to stop at any time, just let me know. Do you have any questions before we start? OK. I'll start the recording now.

I will now ask you a few questions about your background.

1. How many years have you been in practice as an attorney? _____
2. How long have you represented clients in assisted outpatient treatment hearings? _____ (years)
3. During that time, approximately how many AOT cases have you argued? _____
 - 3a. Approximately, how many AOT cases have you argued in the last 3 months _____
4. Aside from AOT hearings, do you represent other clients in other cases involving mental health law?

___ (0) No

___ (1) Yes

APPENDIX 2

[Continued]

4a. If so, how many non-AOT clients do you have? _____

4b. What kind of cases are they? _____

Interviewer: Now, I am going to ask you a few questions about your preparation for AOT hearings.

5. How many open AOT files do you usually have at one time? _____

6. In a typical week, how many clients do you represent in AOT hearings? _____

7. In a typical week, do you meet with AOT clients to discuss their case before their hearing begins?

___ (0) No

___ (1) Yes

7a. How long does that meeting usually last? _____ (minutes)

7b. How long before the hearing does that meeting usually take place? _____ hours _____ days

7c. Is that the only meeting you have with your client before their hearing?

___ (0) no

___ (1) yes

8. On average, in minutes, how much time do you spend on each of the following:ⁱ

a) preparing for an AOT hearing : _____ (minutes)

b) discussing the case with your client: _____ (minutes)

c) reviewing medical records: _____ (minutes)

APPENDIX 2
[Continued]

- d) interviewing clinicians: _____ (minutes)
 - e) interviewing other witnesses: _____ (minutes)
 - f) other activity in preparation for an AOT hearing: _____ (minutes)
9. How many days after an AOT petition has been filed are you notified that you will represent the respondent? _____
10. Kendra's Law requires a hearing no more than three days from the time an AOT petition is filed.
Does that give you enough time to prepare for most AOT hearings?
- ___ (0) No
- ___ (1) Yes
- 10a. If not, how many days after filing an AOT petition should the hearing take place? _____
11. The vast majority of assisted outpatient treatment are granted. What problems do your clients encounter when trying to demonstrate that they no longer need AOT?
- _____
- _____
- _____
- _____
- _____
- _____
12. Can you recall a case where a judge denied the petitioner's request for AOT? Without divulging confidential information, what seemed to make the difference?
- _____
- _____
- _____
- _____

APPENDIX 2

[Continued]

13. What do you think of the AOT Program? What are the strengths of the program? What are the weaknesses?

Interviewer: Now I am going to ask you a few questions about your clients, and your role as an attorney.

14. Many clients consent to AOT, often as a way to get out the hospital. Are there other reasons that might explain why people tend to consent to AOT?

15. Of course, not everyone consents to assisted outpatient treatment. Why do your clients sometimes ask you to challenge AOT?

- 15a. Of those clients who have asked you to challenge AOT, how often have you suspected that the client actually needed to be in assisted outpatient treatment?

[Instruction: read prompts]

- ___ (1) always
- ___ (2) very often
- ___ (3) often
- ___ (4) sometimes

APPENDIX 2

[Continued]

___ (5) rarely

___ (6) never

15b. In those instances, how did you proceed?

Interviewer: Finally, I want to ask a question about the professional responsibilities of attorneys whose clients are mentally ill.

16. *Attorneys whose clients are mentally ill face a well know dilemma. Should they advocate zealously on their clients' behalf, just as they would in any other criminal or civil case? Or should attorneys pursue a collaborative approach focused on the "best interests" of their client? A collaborative or "best interests" approach could mean pursuing court ordered treatment (whether the client wants treatment or not) when the client is clearly mentally ill and their capacity to make treatment decisions is clearly in question. What do you think? How should attorneys proceed?*

17. Is there anything else you think I should know?

APPENDIX 3

JUDGES INTERVIEW INSTRUMENT

Date: ____/____/____ (MM/DD/YY)

County: _____

Judge Interview #: _____

Interviewer: The purpose of this study is to learn more about how judges are implementing Kendra's Law. This interview is completely confidential. I will not use your name in any writings, discussions or lectures produced based on this material. This interview is expected to take approximately 45 minutes. If you decide you want to stop at anytime, just let me know. Do you have any questions before we start? OK. I'll start recording now.

1. How many years have you been an attorney? _____
2. How many years have you been a judge? _____
3. When did you begin hearing petitions for AOT? _____ (year)
4. How many AOT petitions do you hear each week? _____
5. Aside from petitions for AOT, each week, do you hear other cases involving mental health law?
 ___ (0) No
 ___ (1) Yes
- 5a. If so, how many cases do you hear each week? _____
- 5b. What kind of cases are they? _____

Interviewer: Now I am going to ask you a few questions about the time you spend reviewing AOT petitions.

6. On average, how many petitions do you read each day? _____
7. On average, how much time do you spend reviewing each petition? _____ (in minutes)
8. In a typical week, how many days do you have to review petitions before each hearing? _____
9. In a typical week, what percentage of AOT petitions and affirmations do you read all the way through before the hearing starts? _____

APPENDIX 3

[Continued]

Interviewer: Now I'm going to ask you a few questions about the criteria for AOT

10. As you know, Kendra's Law requires "clear and convincing" evidence that the respondent meets the criteria for AOT, however, the term clear and convincing evidence is undefined in the statute. How do you define the term clear and convincing evidence?

11. How do you determine whether the petitioner has established clear and convincing evidence that the respondent meets the criteria for AOT? What are some of the things that you usually look for?

12. Is your decision primarily based on evidence in the written record or evidence presented during the hearing?

- 10a. *Interviewer: ask why decision is primarily based on one source of evidence or another. What problems, if any, are there with the less relied upon source of evidence?*

APPENDIX 3

[Continued]

13. What are the hardest issues you face as a judge when you are deciding AOT cases? Is there a particularly hard case that sticks out in your mind?

14. The vast majority of petitions for assisted outpatient treatment are granted. But of course, not all AOT petitions are granted. Can you recall a case in which the petitioner failed to demonstrate clear and convincing evidence? If so, why was the petitioner's evidence lacking?

Interviewer: Now I am going to ask you a few questions about AOT hearings.

15. How would you describe your role as the judge during an AOT hearing?

Probes: What do we have judges during AOT hearings? What function do they serve?

16. How would you describe the role of a clinician during an AOT hearing?

17. How would you describe the ideal relationship between the judge, as the ultimate decisionmaker, and the clinician, as an expert witness, in the court?

APPENDIX 3

[Continued]

18. How confident are you in the ability of clinicians to determine whether the subject of an AOT petition meets the criteria for AOT? How influential are their recommendations?

19. How would you describe the role of an attorney during an AOT hearing?

- 19a. When an attorney is representing a person with a mental illness during an AOT hearing is it appropriate for the attorney to argue against AOT zealously (assuming the respondent does not want to be in AOT) just as he or she would during a garden variety civil or criminal case?

Probes: are there any important differences that attorneys should keep in mind?

20. What problems, if any, do you see with the AOT hearing process?

- 20a. Does the AOT hearing process give you the information you need to make sound decisions?

APPENDIX 3
[Continued]

20b. Does the AOT hearing process adequately ensure that respondents receive a fair hearing?

20c. Do you see any opportunities to strengthen the process?

21. Is there anything else you think I should know?

APPENDIX 4

Consent Form for Research Participation: Judges and Attorneys

Protocol Title: Kendra's Law: An Empirical Study of Assisted Outpatient Treatment Hearings

Principal Investigator: Candice Player, Esq., M.Phil.

Version Date: May 2011

About this consent form

Please read this form carefully. This form provides important information about participating in a research study. As a prospective research participant, you have the right to take your time in making decisions about participating in this research. If you have any questions about the research or any portion of this form, please ask. If you decide to participate in this research study you will be asked to sign this form. A copy of the signed form will be provided to you for your record.

What is the purpose of this research?

The purpose of this research is to learn more about assisted outpatient treatment (AOT) hearings. This study will include a series of interviews with AOT recipients, judges and attorneys. You have been asked to participate in this research so that we can learn more about how judges and attorneys understand their role in AOT hearings, and what problems if any they perceive in the AOT hearing process.

How many people will take part in this research study?

Fifteen judges and twenty attorneys will be asked to participate in this study.

APPENDIX 4

[Continued]

What will I do in this research?

If you decide to volunteer, you will be asked to participate in one interview. The interview will take approximately 45 minutes. During this interview, I will ask you several questions about AOT hearings. With your permission, I will tape record the interview. I will not ask you to state your name on the recording.

What are the risks and possible discomforts?

The primary risk is that despite my efforts to keep your interview responses confidential, someone might gain access to them. I will do my best to make sure this doesn't happen, and your name will not be on the interview recording or the typed-up version of our interview.

How will you protect my confidentiality? What happens to the information you collect?

Your responses to interview questions will be confidential. I will not tell anyone that you participated in this study or what you said in the interview. The interview will be transcribed. I will keep an electronic copy of both the interview and the transcript in a password protected file. Your name will not be attached. Hard copies of all forms, including this informed consent document, and all interview notes will be kept in a locked file that only I can access. I will store hard and electronic copies of these records for 7 years.

I will use the information you give me for my dissertation. It may be used as the basis for articles or presentations in the future. I won't use your name or information that would identify you in any publications or presentations.

APPENDIX 4

[Continued]

Are there any benefits from being in this study?

Study participation involves no direct benefits to you. You will help us learn more about AOT.

Will I get paid for participating in this study?

You will not be paid for your participation in this study.

Can I end my participation in this research early?

Your participation is completely voluntary, and you may withdraw from the study at any time. If you want to stop, just tell me.

If I have any questions or concerns about this research, who can I talk to?

If you have questions or concerns about this research, you can contact me, Candice Player, at (718) 490-4240, or via email: cplayer@fas.harvard.edu

If you wish to speak to someone not directly involved in this research about your rights as a research subject, please contact Jane Calhoun, Harvard University Committee on the Use of Human Subjects in Research, 1414 Massachusetts Avenue, Room 234, Cambridge, MA 02138.

Phone: 617-495-5459. E-mail: jcalhoun@fas.harvard.edu

Agreement:

I have discussed with _____ the above procedures, explicitly pointing out potential risks or discomforts. I have asked whether any questions remain and have answered these questions to the best of my ability.

APPENDIX 4
[Continued]

(date) (investigator's signature)

The nature and purpose of this research have been sufficiently explained and I agree to participate in this study. I understand that I am free to withdraw at any time without any penalty.

Signature: _____ Date: _____

Name (print): _____